

**UnityPoint Health – Trinity**  
**Tier 2 Education Assistance Application**  
**TCNHS Programs**

Employee's Name \_\_\_\_\_ Employee # \_\_\_\_\_

Department \_\_\_\_\_ Position \_\_\_\_\_

 Program Enrolled:     BSN – A     BSN – B     BSN – C  
                                   BSHS                       MSN

Employment Status (FTE): \_\_\_\_\_

I understand the terms and conditions of UnityPoint Health – Trinity's Educational Assistance for Tier 2 benefits as defined in the Educational Assistance Plan Policy. I also understand that the educational assistance will start and continue for three consecutive calendar years with a \$5,250.00 maximum per calendar, which is equal to three full years for a maximum funding of \$15,750.

I will maintain a grade of "C" (2.0) or better in all courses. I authorize Trinity College of Nursing & Health Sciences to provide semester grades, class drops, and graduation documentation to Trinity Regional Health System's Human Resource Office. I understand that failure to maintain proper grades will cancel my benefit for future semesters. I also understand that after cancellation I must successfully complete one semester, and meet grade requirements, in order to be reinstated.

My anticipated degree completion date is \_\_\_\_\_.

<b>Education Assistance Years:</b>			
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<b>Work Commitment Begins:</b>		<b>Work Commitment Ends:</b>	
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I fully understand that in accepting this educational assistance, I am agreeing to work for UnityPoint Health-Trinity in a regular employment status for a period of not less than **three** years following the date grades are provided to Human Resources. Furthermore, I agree that if I do not complete my three year work commitment, I am required to repay a prorated amount based on the total assistance dollars provided to me. The prorated amount shall be based upon work commitment completed. Also, I fully understand that if I withdraw from the chosen degree program, I am required to repay the funds in full. I further understand that by executing this application, I hereby agree to make said payment upon demand of Trinity if I fail to meet requirements and to repay said amount in full upon demand or will be subject to interest of 10% from the time of demand, plus attorney fees and costs incurred in collection. UnityPoint Health-Trinity reserves the right to waive this commitment in the event that I am involuntarily terminated.

I am also aware that UnityPoint Health – Trinity accepts no responsibility regarding the possible designation of employer-provided tuition reimbursement as taxable income and will report payments according to IRS requirements.

 \_\_\_\_\_  
 Employee's Signature

 \_\_\_\_\_  
 Date

 \_\_\_\_\_  
 Manager Signature

 \_\_\_\_\_  
 Date

 \_\_\_\_\_  
 Manager, Organizational Development

 \_\_\_\_\_  
 Date