



American Senior Certification Reimbursement Request Form Communities

Complete separate request form for each certification

Employee Name: _____		Employee ID: _____	
Date of Hire: _____		Status: _____	
Job Title: _____		Facility Name/Number: _____	
Date of Request: _____		Educational Institution/Vendor: _____	
Certification Program: _____ _____			
Start Date: _____		End Date: _____	
Maximum annual reimbursement is \$500; see Certification Reimbursement Policy for requirements for application and reimbursement.			
Reimburse me by (circle one): Check Direct Deposit (complete Direct Deposit Form Certification and Nurse Licensing)			
Employee Signature:* _____		Date: _____	
<i>*By signing, you acknowledge you have read and understand the Certification Reimbursement Policy, including the post-program length of service obligations.</i>			
Approval: (must be prior to start of program)			
ED Signature: _____		Date: _____	
<i>(Home Office employees: please obtain your department supervisor's approval signature.)</i>			

Home Office Use Only	
Denial reason: _____	
Approved: _____	
Sr. Director of Benefits: _____	Date: _____

Potential Reimbursement:	Amount Used Year to Date:
Total Expenses Confirmed for Reimbursement:	
Date Submitted to Accounting:	Request Processed By: