El Camino Hospital
THE HOSPITAL OF SILICON VALLEY

Application for Certification Reimbursement

1. COMPLETE APPLICANT INFORMATION:

Employee Name:_____ **Date:** _____

Department Name:_____ **Manager Name:** _____

2. SPECIFY TYPE OF CERTIFICATION:

Type of Certification:_____**Certifying Organization:**_____

Check One: Initial Certification _____ **OR** **Recertification** _____

Date Achieved:_____ **Next Renewal Date:** _____

3. DOCUMENTATION OF EXPENSES:

List all individual expenses and attach all supporting documentation (i.e. receipts and documentation of certification achievement.) Expenses reimbursed under your Certification Reimbursement cannot be reimbursed under any other plan or program. Only certification-related required expenses are eligible for reimbursement.

Eligible Itemized Expenses ***(may include preparation class, required books and materials, and testing fees for successful completion)***	**Cost**	**Documentation Attached:**
Total		

(x) I attest the information contained herein is accurate and true, and that the Hospital has the right to confirm.

_____

Applicant Signature **Date**

5. FORWARD TO DEPARTMENT MANAGER FOR SIGNATURE:

DEPARTMENT MANAGER: REIMBURSEMENT WILL BE CHARGED BACK TO YOUR DEPT. **PLEASE COMPLETE:**

PRI	SUB	DEPT

(x)_____

Department Manager Signature **Date**

6. FORWARD TO THE EDUCATION DEPARTMENT AT: GC30

(x)_____

Director of Clinical Education Signature **Date**

For Education Department use only: Received in Education_____Submitted to Payroll _____

Revised, November, 2016