TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

HEALTHCARE EDUCATION SCHOLARS PROGRAM

Employee Name:_____

Title:_____ R#:_____

School/Department:_____

Campus Mailing Address:_____

Phone:_____

Begin Date of Educational Program:_____ End Date of Educational Program:_____

College/University and Educational Program for Consideration:_____

Describe the educational program and how participation will benefit TTUHSC:

_____

_____

_____

_____

Itemize total program cost, including tuition, fees and other expenses, shall not exceed $50,000:

_____

_____

_____

I agree that I will continue my full-time employment with TTUHSC for at least one month for each month of the development. If I fail to do so, I will reimburse TTUHSC for all the costs associated with the development, including any amount of salary that I received that is not accounted for as paid vacation or compensatory leave.

Employee Signature:_____ Date:_____

Approval:

Department Signature:_____ Date:_____

Dean/Vice Signature:_____ Date:_____

Provost:_____ Date:_____

Submit to: Office of the Provost