DC | HEALTH

**District of Columbia Department of Health**
**Office of Human Resources**
**Tuition Assistance Program Application**

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Complete Sections I and II of this application and submit to the TAP Coordinator in the Office of Human Resources. This application is subject to final approval by the Director or his/her designee. A course description must accompany this application.

## Section I- Employee Information

Name (Last, First, Middle) _____ Employee ID _____

Home Address _____ City _____ State _____ ZIP _____

Phone _____ Administration _____ Job Title _____

Email _____ Educational Institution _____

Degree Pursued _____ Area of Study _____

Academic Term _____ Start Date _____ End Date _____

Comments _____

Have you received TAP assistance previously? _____ If yes, which academic term? _____

Cost of course(s) _____ Cost per Credit Hour _____

## Section II- Requested Courses

| Course Title | Course Number | Credit Hours | Class Days and Times |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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My signature below certifies that the information provided herein is accurate and truthful. I understand that I must receive a grade equivalent of "C" or better in each undergraduate course or a grade equivalent of "B" or better in each graduate course. I understand that the amount of money I receive in TAP assistance in a fiscal year may not exceed the year's maximum TAP funding per employee. Please inquire with the TAP Coordinator in DOH HR with any questions about the current year's maximum TAP funding per employee. A copy of my grade report must be submitted to the DOH TAP Coordinator upon completion of the course(s) to receive reimbursement. I have read SOP 530.000 Tuition Assistance Program and agree to abide by the the policy and procedures of the TAP Program, including the requirement to remain an employee of the DC Department of Health for a period of 24 months after the completion of the most recent course.

Signature _____ Date _____

**Section III- Supervisor Review and Conditional Approval of Funding**

Supervisor Name | Resolution

Date

Index | PCA | Object Class

Comments if Request Denied

By approving this request, I certify that the employee's participation will not adversely affect departmental services, nor cause undue hardship for other employees. Additionally, funding is conditionally available for this request. If class attendance during the workday is being permitted, documentation of the alternate work schedule must be attached.

**Section IV- TAP Coordinator Processing**

Date Received | Forwarded to OCFO for processing ☐ | Date

Index | PCA | Object Class

Comments

Signature | Date

**Section V- Director (or Designee) Review for Payment Processing**

Resolution | Date

Comments if Request Denied

Signature | Date

CC: Copy to employee
Copy to tuition assistance file
Copy to administration DDO