GOVERNMENT OF THE DISTRICT OF COLUMBIA

D.C. DEPARTMENT OF HEALTH TUITION ASSISTANCE PROGRAM

AGREEMENT TO CONTINUE IN SERVICE

(Carefully read this agreement for Continuation of Service.)

Tis form should be signed by the applicant and witnessed by the TAP Coordinator or designee.)

Name:_____ Contact Number:_____

Administration:_____

Employee Number: _____

Course Title(s): _____

_____

_____

Course Date(s):_____

_____

1. I, _____, agree that upon completion of the courses listed

(Printed Name)

above and listed in my Application to the Department of Health Tuition Assistance Program, I will remain an employee of the District of Columbia for a period of 24 months after completion of my last course.

I AGREE that the period shall be computed by the appropriate authority, from official records, and that it shall commence on the first (1st) day following the end of course completion.

2. I AGREE that if I receive tuition assistance and leave the Department of Health (DC Health) employment before the 24 month period, **I AM OBLIGATED TO REPAY TO DTHE DEPARTMENT OF HEALTH THE PRO-RATED AMOUNT DUE, DEPENDING ON THE NUMBER OF MONTHS REMAINING BEFORE THE 24- MONTH COMMITMENT IS MET. THE AMOUNT OF REPAID TUITION ASSISTANCE FUNDS MAY BE REDUCED OR WAIVED BY THE DEPARTMENT DIRECTOR, IN THE EVENT THAT I AM SEPARATED FROM EMPLOYMENT DUE TO A REDUCTION-IN-FORCE. SHOULD I BE SEPARATED FOR CAUSE, I SHALL REPAY THE DEPARTMENT OF HEALTH THE PRORATED AMOUNT, DEPENDING ON THE NUMBER OF MONTHS REMAINING BEFORE THE 24-MONTH COMMITMENT IS MET. THE AMOUNT OF**

THE REPAID TUITION ASSISTANCE FUNDS MAY BE REDUCED OR WAIVED BY THE DEPARTMENT DIRECTOR.

3. I AGREE that as a recipient of tuition assistance, **I AUTHORIZE THE DEPARTMENT OF HEALTH TO DEDUCT THE BALANCE OWED FOR TUITION ASSISTANCE FROM MY PAYCHECK OR ANY OTHER FINAL PAYMENTS DUE ME.**

4. **I UNDERSTAND THAT ANY AMOUNTS WHICH MAY BE DUE TO THE AGENCY AS A RESULT OF ANY FAILURE ON MY PART TO MEET THE TERMS OF THIS AGREEMENT MAY BE WITHHELD FROM ANY MONIES OWED ME BY THE DISTRICT GOVERNMENT, OR MAY BE RECOVERED BY SUCH OTHER METHODS AS PROVIDED BY LAW.**

5. Should I elect to resign from my position at the Department of Health before fulfilling my 24 month obligation, I AGREE to give my agency, through my immediate supervisor, advanced notice of at least 10 workdays, during which time a determination concerning reimbursement will be made. If I fail to give advanced notice, or I am not given written notice of waiver of payment, I AGREE to repay the amount of expenses incurred by the District Government.

6. As a recipient of tuition assistance, I authorize the Department of Health, through the provisions of the *District Personnel Manual; Chapter 29, Employee Debt Set-Offs,* to deduct the balance owed to DOH, the employee will pay the balance owed to the Agency by personal check, cash, or money order on or before his/her final workday.

7. The tuition assistance does not have to be repaid if the employee is unable to work due to a long term illness or other serious medical condition prohibiting them from work or if the employee dies. A written request for waiver of repayment shall be submitted to the Department Director.

8. I UNDERSTAND that this agreement does not commit the District government to continue my employment.

SIGNATURE:_____ DATE:_____

PRINTED NAME:_____

WITNESSED:_____ DATE:_____

TAP Coordinator or Designee