

St. Clair County Community Mental Health
Application for Training/Endorsement/Certification Reimbursement

Employee Name: _____ Date: _____

Program Site: _____ Job Title/Grade: _____

Date of Hire: _____

Name of Training or Special Endorsement to be taken: _____

Dates of Training(s): _____

Expected Completion Date: _____

Professional Goal Statement: (Please tell us why you are interested in the program as well as any other relevant information you wish to include; attach additional sheet if necessary):

Please Note: Additional documentation may need to be completed and more area specific questions answered for the training/endorsement as required.

Staff Signature

ADMINISTRATIVE REVIEW

This application has been reviewed and tuition reimbursement is **GRANTED** for the following: _____

NOT GRANTED:

Rationale: _____

Chief Executive Officer/Designee Signature:

Executive Team Review Date: _____

Class Completed: _____

Grade: _____

Reimbursed Date: _____

Amount: _____

cc: Employee
Supervisor
Personnel File