

## HCHF Agreement for Educational Assistance

The Harper County Health Foundation is pleased to commit to your educational pursuits. Below is the agreement we ask you to complete.

This **Agreement for Educational Assistance** ("Agreement") is made and entered into this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_ by and between Harper County Health Foundation ("HCHF") and \_\_\_\_\_ ("Employee").

1. HCHF will sponsor the Employee by providing financial assistance leading to Employee obtaining the degree/certification the Employee claims to pursue.
2. HCHF agrees to provide financial assistance in the gross amount of \$\_\_\_\_\_ ("Assistance"). ***Final amount of financial assistance will be determined upon completion of the course of study.*** In consideration for such financial assistance, Employee agrees to remain employed in a full time position with any healthcare facility in Harper County, Kansas for 36 months (3 years) from the date of completion of the program.
3. In the event Employee voluntarily terminates his/her full time employment before completing the course of study, fails to obtain certification/licensure, fails to complete the Full Time Commitment, or does not perform satisfactorily, Employee agrees to repay HCHF a prorated amount of the Assistance upon the end of employment or failure to meet the requirements of the sponsored position. The pro-rated amount owed HCHF is based upon the number of months the Employee has been employed in the sponsored position or the date the employee fails to achieve requirements for the position. For each month Employee remains employed at PHC, \$300 of the Assistance will be deemed repaid to HCHF. If PHC involuntarily terminates Employee's full-time employment for grounds other than unsatisfactory performance or a violation of PHC's policies, Employee will not be liable to repay the Assistance.
4. Employee acknowledges and affirms Employee has read the above and foregoing, understands it and is voluntarily entering into this agreement.

**Employee:**

**Date:**

**Signature:**

**HCHF Officer Name:**

**Date:**

**Signature:**

