



&



Staff Education Enhancement Program Assistance Application

Name _____
 Title _____
 Dept. _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ E-Mail _____

Course Description

Course Location _____ Course Date(s) _____

Course Cost* _____ Distance from MMH (miles) _____

(Note: Applicant please initial the following 3 conditions)

_____ I understand that Massena Memorial Hospital may not compensate me for wages and/or scheduling in order to attend this class/seminar/conference.

_____ As a condition of receiving this grant to attend the above mentioned class/seminar/conference, I agree to provide an educational in-service training for my department co-workers at Massena Memorial Hospital within 7 business days.

_____ A copy of the class/seminar/conference application form is attached to this application.

_____ / _____ / _____ _____ / _____ / _____
Applicant Signature *Date* *Supervisor Day(s) Off Approval*

* Applicant Please Note- a decision on you application will be made within 7 business days.

_____ / _____ / _____ _____ _____ _____ _____
S.E.E.P. Committee Met On *Approved* *Amount* *Denied* *S.E.E.P. Committee Member Signature*

Notes: _____

For further information please contact Laurie Schneller in the Staff Development Office by calling (315) 769-4338 Or Julia Rose of the Massena Memorial Hospital Foundation by calling (315) 769-4602.

PLEASE SUBMIT COMPLETED APPLICATIONS TO STAFF DEVELOPMENT OFFICE.

