# Part-Time Faculty Medical Reimbursement Request Form

EMPLOYEE NAME:_____ SEMESTER:_____

DIV/DEPT. NAME:_____ EMPLOYEE ID:_____

PHONE/OFFICE EXTENSION:_____ E-MAIL:_____

## PART A: PROGRAM ELIGIBILITY (to be completed by employee)

**Eligibility:** Part-time instructional faculty will have completed at least a 40% load the same semester in which they are applying for reimbursement.

**a)** Part-time instructional faculty will have completed at least a 40% load the same semester in which they are applying for reimbursement.
*AND*
**b)** Instructional faculty must have taught at least 40% of a full-time load for at least three semesters within a three-year period, not including the semester in which applying for reimbursement.

**c)** Part-time non-instructional faculty will have completed at least 234 total hours the same semester in which they are applying for reimbursement.
*AND*
**d)** Non-Instructional faculty must have worked 234 total hours for at least three semesters within a three-year period, not including the semester in which applying for reimbursement.

Approved absences as reported on the Absence Certification form provided by the District count towards the total hours required for instructional and non-instructional computation. However, a minimum of 75% of the 234 total hours or 75% of the 40% load must be on a paid status.

**I am requesting reimbursement for employee-incurred expenses as follows ($1,000 maximum):**

| | | |
|---|---|---|
| **Medical** | Insurance Premium | **$**_____ |
| | **-OR-** | |
| | Doctor visits, procedures, labs, prescriptions | **$**_____ |
| **Dental** | Insurance Premium | **$**_____ |
| | **-OR-** | |
| | Dental visits, procedures, labs, prescriptions | **$**_____ |
| | **TOTAL REQUEST** | **$**_____ |

I certify that the expenses submitted for reimbursement have not already been reimbursed from any other source and any indication to the contrary may disqualify my participation in the Part-time Faculty Medical Reimbursement Program in the future.

**Employee Signature**:_____ **Date**: _____

## PART B: ELIGIBILITY VERIFICATION (To Be Completed by Human Resources Only)

| **Date form was received:** | **Date adjusted form was received (if applicable):** |
|---|---|

_____ **YES. Request for reimbursement is approved.** All the required program criteria have been met and verified. Required proof of medical/dental plan enrollment and premium payments are included.

_____ **NO. Request for reimbursement is denied.**

Denial reason: _____

Total amount approved: $_____ Date submitted to Payroll: _____

HR Staff Member Review:_____ Date:_____

HR Manager Approved:_____ Date: _____