

TRAINING JUSTIFICATION AND ANTICIPATED COST (TJAC)

For use by UC San Diego Health System Employees Only

Before completing the TJAC form, please review UCSD Implementing Procedures for Personnel Policy for Staff Members: 50/Professional Development (HR-S-1) and 51/Reduced Fee Enrollment (HR-S-1). To avoid possible processing delays, please complete the form thoroughly and submit it for processing approval at least four weeks prior to the beginning of the class.

Submit your TJAC form to UC San Diego Health Systems Human Resources Department at Mail Code 8929.

1. Employee Name _____ UCSD Employee ID _____
2. Payroll Title _____ Career Employee? Yes__ No __ Date of Hire _____
3. Department _____ Mail Code _____ Phone _____ E-mail _____
4. Name of Department Business Officer _____
Mail Code _____

A. TYPE OF REQUEST:

1. 66% Reduced Fee Enrollment at UC _____ (specify campus, e.g. UCSD, UCI, UCLA, etc.)
Undergraduate: __ Graduate: __
Spring: __ Winter: __ Fall: __ of 20____ (Year)
2. 10% (up to \$50.00) Discount at UCSD Extended and Public Services, Departmental Recharge to:
7-digit Account Index Number _____
3. Discount at Summer Session, Departmental Recharge to:
7-digit Account Index Number _____
4. Departmental Recharge for Concurrent Enrollment to:
7-digit Account Index Number _____
5. Other training institution(s) _____
Undergraduate: __ Graduate: __
Spring: __ Winter: __ Fall: __ of 20____ (Year)
6. Additional Request for:
Advance Payment
Reimbursement upon payment of fees
Reimbursement upon successful completion (see Section E)
Time off with pay, Number of hours _____ per week, total of _____ hours.
Alternate Work Schedule, Please specify

B. COURSE INFORMATION:

- | Course Title(s)/Section ID/Number of Units/Dates and Times of Course(s): | Job Related? |
|--|--|
| 1. _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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C. COSTS TO BE BORNE BY DEPARTMENT

Fees: _____
Books: _____
Overtime: _____
Other: _____
Explain: _____ Total: _____

COSTS TO BE BORNE BY EMPLOYEE

Fees: _____
Books: _____
Overtime: _____
Other: _____
Explain: _____ Total: _____

D. JUSTIFICATION FOR THIS REQUEST: **

Approval:

Supervisor's Signature Date

Department Head's Signature Date

Approved for:

- Departmental Recharge (For UCSD Extended and Public Service Courses Only)
- 66% Reduced Fee Enrollment
- Reimbursement
- Reimbursement Upon Successful Completion
- Time Off with Pay
- Alternate Work Schedule
- Advanced Payment (For institutions that do not accept UCSD recharges)

Director, UCSD HealthCare Education Development and Research— Date

E. REIMBURSEMENT/REIMBURSEMENT UPON SUCCESSFUL COMPLETION:

Return this form with your Supervisor's signature below, along with the following items for approval:

1. Completed Request for Issuance of Check Form;
2. Proof of payment; and
3. Proof of attendance or grade card (for reimbursement upon successful completion only).

Supervisor's Signature Date

Director, UCSD HealthCare Education Development and Research Date

e: **The Tax Reform Act of 1986 requires the University to request this information. The value of non-job related reimbursed or tuition reduced graduate and professional courses may be reportable as income for income tax purposes.