



# KNOWLEDGE ENHANCEMENT PROGRAM Request for Approval / Reimbursement

Employee Name: \_\_\_\_\_

Employee ID: \_\_\_\_\_

The Knowledge Enhancement Program benefit is available after three (3) full months of employment to regular full-time employees who are on active payroll when a Knowledge Enhancement Program event both starts and ends. Employees must remain employed for six (6) consecutive months after completing the training in order to retain the full benefit.

**APPROVAL MUST BE OBTAINED BEFORE YOU REGISTER for the event in order to be eligible for reimbursement.**

### KNOWLEDGE ENHANCEMENT PROGRAM EVENT:

<input type="checkbox"/> Seminar	<input type="checkbox"/> Conference	<input type="checkbox"/> Certification Program	<input type="checkbox"/> College Course	<input type="checkbox"/> Professional Membership
<input type="checkbox"/> Star12 Enterprise	<input type="checkbox"/> Other (please specify)			

Name of Event: \_\_\_\_\_

Name of Organization Providing Event: \_\_\_\_\_

Event Location (city/state): \_\_\_\_\_

### EVENT DATES: Official documentation of course dates must be provided

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Registration Deadline: \_\_\_\_\_

Copy of Event brochure, or equivalent must be attached **(REQUIRED)**

### **RATIONALE FOR ATTENDANCE:** Attach on a separate sheet.

Be sure to describe the direct relationship and benefit to your current position and/or objectives. Also include your name and the name of the Knowledge Enhancement Program event.

Event Cost / Fee: \_\_\_\_\_ Travel Required?  Yes  No

Mileage: \_\_\_\_\_ Taxi/Shuttle: \_\_\_\_\_ Airfare: \_\_\_\_\_ Lodging: \_\_\_\_\_

Anticipated Hotel Room Cost: \_\_\_\_\_ Name & Location of Hotel: \_\_\_\_\_

Other Cost: \_\_\_\_\_ Other - Explanation: \_\_\_\_\_

Total Reimbursable Costs: \$ \_\_\_\_\_

What is the total number of hours you anticipate missing from work in order to attend this event? \_\_\_\_\_

**KEP events should be scheduled during regular scheduled days off and/or personal time. In the event that the KEP event can only be taken during regular business hours, the use of KEP labor may be approved. Supervisor: KEP labor must be approved below**

Will you use PTO to attend the event?  Yes  No IF YES, how many hours of PTO will be used? \_\_\_\_\_

Will you use KEP Labor to attend the event?  Yes  No IF YES, how many hours of KEP Labor will be used? \_\_\_\_\_

Total Approved KEP Labor Hours: \_\_\_\_\_ *(Completed by PGM/Department Head)*

Supervisor Rationale for KEP Labor: \_\_\_\_\_

Total Labor Cost: \_\_\_\_\_ *(Completed by Accounting)* \_\_\_\_\_ *PGM Approval*

By signing below, I agree that should I leave ASTRIX voluntarily within six months of any payments made by ASTRIX to me or on my behalf for benefits under the KEP policy, ASTRIX may deduct up to the full amount paid from my final paycheck. I further agree that should my final paycheck not constitute full repayment, I will repay any additional amount within two weeks of my termination. Finally, should I breach this obligation and ASTRIX is required to initiate legal action to collect outstanding amounts from me, I agree that ASTRIX may recover from me any legal fees and costs incurred in that legal action.

Employee Signature: \_\_\_\_\_ Date of Request: \_\_\_\_\_

**IMPORTANT NOTICE:** You must attach to this form the appropriate supporting documentation for your KEP event and Travel costs. Such documentation must be thorough and complete and all costs related to travel must be within the limits of the Federal Travel Regulations - please refer to <http://www.gsa.gov/portal/content/104790> AND ASTRIX KEP (EH79) & Travel & Expense Policies

Approved  Declined Reason not approved: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date of Decision: \_\_\_\_\_

PGM/Dept Head Signature: \_\_\_\_\_ Date of Decision: \_\_\_\_\_

For Accounting Use Only:  
Accounting Approved: \_\_\_\_\_ Date of Approval: \_\_\_\_\_

Available Annual KEP: \_\_\_\_\_ KEP Year: **2012**

Reimbursed YTD KEP: \_\_\_\_\_ Pending KEP Approved: \_\_\_\_\_ NEW KEP Balance: \_\_\_\_\_ Approval Sent to Employee

*(Paid to Employee) (Approved, not yet Reimbursed) (Balance after this Request)*

**IMPORTANT NOTICE:** ALL reimbursable costs are to be submitted on a single ASTRIX Expense Report (form S13)