Graduate Medical Education
263 FARMINGTON AVENUE, LM068
FARMINGTON, CT 06030-1921
PHONE 860.679.2147
FAX 860.679.4624

Capital Area Health Consortium
270 FARMINGTON AVENUE, SUITE 352
FARMINGTON, CT 06032-1994
PHONE 860.676.1110
FAX 860.676.1303

SALARY ADVANCE AGREEMENT

Name: ____

Program: ____

Local
Address: ____

Amount
Requested: _____________ (Maximum of $2,000)

I agree to repay Capital Area Health Consortium for the salary advance by ten consecutive and equal payroll deductions beginning approximately a month after my start date. If my employment ends before the full amount is paid, I authorize the balance to be deducted from my final pay.

___________________________ ___________________________
Employee Signature Date

___________________________ ___________________________
Program Signature Date

___________________________ ___________________________
Consortium Signature Date

An Equal Opportunity Employer