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: ___________________________________

CT Address: ___________________________________

Amount Requested: ___________________________________ (Maximum of $2,000 is allowed)

Please indicate if the check is to be: Picked up from the Consortium's Office or

Mailed to your local Connecticut address

I agree to reimburse Capital Area Health Consortium for the salary advance by making ten consecutive and equal payroll deductions beginning in August. If my employment ends before the full repayment, I authorize the remaining balance to be deducted from my final pay.

___________________________________ ____________________

Employee Signature Date

___________________________________ ____________________

Program Signature Date

___________________________________ ____________________

Consortium Signature Date