SAMPLE PROMISSORY NOTE

In the amount of **<Amount>**

Newton, Massachusetts
Date:**<Date>**

Financial Assistance Related to the Tuition Assistance Plan

In consideration of being allowed to participate in Atrius Health Tuition Assistance Plan and to register for the following educational course or program entitled **<Course Title>** , taken during my employment at Atrius Health over the time period of **<Start Date>** (beginning) through **<End Date>** (ending) , I, the undersigned, **<Name>**, hereby understand that Atrius Health will pay tuition on my behalf directly to me and I execute this Promissory Note ("Note") to Atrius Health in the Sum of **<Amount>** ("Sum") and agree to the following:

- If I fail to provide Atrius Health with satisfactory evidence of passing the above named educational course or program with a grade of C minus or better for undergraduate courses, and B minus or better for graduate courses, within 60 days of course completion, or
- If I fail to provide Atrius Health with satisfactory evidence of successful completion of the program, if letter grades are not given by the instructor,

I agree to reimburse Atrius Health the Sum by **<60 days past>** . I understand that I will be in default on this Note if I fail to make reimbursement of the full amount of the Sum by **<60 days past>.**

- If I withdraw from the course or program, receive an "incomplete," or
- If my FTE falls below .50 within one year of the completion of the stated coursework, or
- If my employment with Atrius Health terminates for any reason prior to reimbursing Atrius Health the sum I was advanced,
- If my employment with Atrius Health terminates for any reason while the course or program is in session or within one year of the last day of the semester in which the course or program is offered,

I agree to reimburse Atrius Health the Sum immediately. I understand that I will be in default on this Note if I fail to make reimbursement of the full amount.

If I fail to make any of the payments due under this Note, I hereby authorize Atrius Health to deduct the amount of this Note from my next (or any subsequent) scheduled paycheck(s) and/or vacation "cash out" check. In its sole discretion, Atrius Health may establish a payment plan for repayment of this Note.

No delay or omission of the part of Atrius Health in exercising any right hereunder shall operate as a waiver of such right or of any other right of such holder, nor shall any delay, omission or waiver on any one occasion be deemed a bar to or waiver of the same or any other right on any future occasion.

The acceptance by Atrius Health of any payment after any default hereunder shall not operate to extend the time of payment of any amount then remaining unpaid hereunder or constitute a waiver of any rights of the holder hereunder.

Should this Note be placed in the hands of a collection agency or attorney for collection, or suit be brought to collect the outstanding balance, I agree to pay all costs of collection, including but not limited to collection agency costs and fees, court costs and expenses, and reasonable attorney's fees.

All rights and obligations hereunder shall be governed by and construed in accordance with the laws of the Commonwealth of Massachusetts.

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I have executed this Note as of _____.
Date

I acknowledge that I have read this Note and agree to its terms.

_____SAMPLE_____
Employee Signature

_____SAMPLE_____
Supervisor Name – Please print name

_____SAMPLE_____ _____
Supervisor Signature Date

SAMPLE