



Reimbursement/Stipend – FY2010
C/SE ABLEResource Center

To receive a reimbursement/stipend, please complete and submit this form to the Central/Southeast ABLEResource Center within 30 days of completion of the activity. Activities must be completed and paid for during the same fiscal year (which ends June 30th). Do not use this form for alternative delivery professional development.

PARTICIPANT INFORMATION:
(Please type or print clearly)

Name _____ Email Address _____
Home Address _____
City _____ State _____ Zip _____ - _____
Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____
Social Security No. _____ (Check cannot be issued without the SSN)
ABLE Program _____ Position _____
(not name of site where you work)

ACTIVITY INFORMATION:

Activity Title _____ Activity Sponsor _____
Location _____ Date of Activity _____
Length of Activity: (select one)
_____ Full day (4 or more contact hours) _____ half day (2.5 to 4 contact hours)
_____ Other (Explain) _____

I assure that the above activity is relevant to my ABLEResource position. Expected Reimbursement _____
(Original receipts required)

Signature _____ Date _____

I assure that the above activity received my approval and was satisfactorily completed.

Program Director (or Designee) _____ Date _____

This voucher is approved for payment. Pay this amount:
Stipend _____
Reimbursement _____

Resource Center Director _____ Date _____