Central/Southeast ABLE Resource Center

Request for Reimbursement Form

In order to receive payment, this form must be completed and submitted to the Central/Southeast ABLE Resource Center within 30 days of the completion of the activity. **Please attach all receipts.**

PARTICPANT INFORMATION: Please read the ***Guidelines for Professional Reimbursement*** (also downloadable from the Forms page at our website: www.able-ohiou.org) before providing the requested information.

Please type or print clearly

Name _____

Home Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____

Work Phone (_____) _____

Social Security Number _____
(Check cannot be issued without SSN)

ABLE Program _____

Position _____

ACTIVITY INFORMATION:

Activity Title _____

Activity Sponsor _____

Location _____

Date(s) of Activity _____

PARTICIPANT SIGNATURE
Your signature indicates that you have read the Guidelines for Professional Development Reimbursement and understand that you may not be eligible to receive stipends for other training activities. Your signature also indicates that you are employed 7 or more hours per week through the ABLE grant.

_____ _____
Signature Date

DIRECTOR'S SIGNATURE
Since you are applying for payment for a professional development activity that was not sponsored by the Central/Southeast ABLE Resource Center, please have you director sign below. Your director's signature signifies his/her approval of your attendance at the activity, as well as, documentation of attendance and verification that you are employed 7 or more hours per week through the ABLE grant.

_____ _____
Director's Signature Date

Please make sure to keep a copy of this form and your receipts for your records and mail the original with your original receipts to: C/SE ABLE Resource Center, OU 338 McCracken Hall, Athens, OH 45701

For Resource Center use only:

Conference Allocation $ _____

Reimbursable Expenses:

a. Registration $ _____

b. Meals $ _____

c. Hotel $ _____

d. Parking $ _____

e. Taxi $ _____

f. Airfare $ _____

g. Other $ _____

Total Expenses a-g **$** _____

Total Reimbursement: **$** _____
(allocation minus expenses)

Notes:

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☐ **Eligible for future stipend(s)**

☐ **Stipend allocation met for the program year**