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|  | Non-Employee Payment Candidate**COMPLETED FORM MUST BE SUBMITTED BY THE DEPARTMENT WITH** **SUPPORTING DOCUMENTATION TO ACCOUNTS PAYABLE**  |
|   |
| Department:  | Human Resources | Dept. Contact: Angela Montemarano |  Dept. Tel. No. 420-2107  |
| Payee Name: |  |   |
|   |  |
| **Address (reimbursement will be mailed to):**  | **Email address:** |
| Please indicate one of the following:  |
| A Citizen of the United States | [ ]  | Yes |  [ ]  | No. |  |
| Permanent US Resident | [ ]  | Yes |  [ ]  | No. | If yes, provide copy of alien registration card |
| Non-Resident Alien (NRA) | **[ ]**  | Yes | **[ ]**  | No. | If yes, Country of Citizenship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Immigration status on I-94 card or passport: |
| **Description of Service:** |  |
| Position: |  |
|  |
| Date(s) of Stay: | From:  |        |       |       |  To: |       |       |       |
|  |
| **COMPLETE**  |
| **Travel Expenses Claimed (Original receipts must be submitted.)**Hotel/Lodging: 90111501 $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Meals: 90101501 $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Airfare 78111500 $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Taxi 78111804 $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Bus 78111802 $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Train/Bus : 78111600 $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Auto-Rental 78111808 $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Personal Car: 25101503 \_\_\_\_\_miles @ $.56 per mile Bridges/Tolls: 78111800 $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ =$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parking: 78111807 $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Misc.-Please list $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***Total Travel Expenses Claimed*: $\_\_\_\_\_\_\_\_\_\_**\_\_\_**\_\_\_\_ TOTAL PAYMENT: $** \_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_** |
|  |  |
| **Payee Certification** |
| I certify that the above services will be/have been performed and that the reimbursement claimed, **and representations made in support of** **payment, are true and accurate..** |
|       |  |       |
|  | Payee Signature |  | Date |  |
| **Certification of the Account Director** |
| I certify that the services are essential to the project, and cannot be provided by any other person receiving salary support, and the rate is |
| appropriate, based on the qualifications of the selectee and the nature of the work to be done. **I am aware of no relationship between the** **independent contractor and any department employee.** |
|  |
| State Account  |  | Dept. Head Signature  |       |
|  |       | Department Head Printed Name  |       |
|  |  | Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **DEAN /VP APPROVAL:**   | **ADMIN. & FINANCE APPROVAL** |  |
|  |  |  |
|  |  |  |  |  |  |  |  |  |
| Authorized Signature |  | Date | Authorized Signature |  | Date |  |  |  |
|  |