**National Association of Chronic Disease Directors**
Stipend-Honorarium Payment Confirmation- Federal Funded Programs

Note: Please send completed document to ap.nacdd@chronicdisease.org

Name of Stipend/Honorarium Recipient: _____

Name of employer of above recipient: _____

Name of event/activity: _____

Period of Performance: _____

NACDD Finance Code (8 digits): _____

Description of services to be provided:

*The below signature confirms that I have not and will not receive payment from my employer or another entity for the above described services.*

Recipient's signature: _____

Date: _____

*My institution allows for individual honorarium/stipends with the understanding that expenses allocable to another federal program are not allowable expenses to this federal funded program and to do so would be in violation of the federal regulations.*

Institution's signature: _____

Job title: _____

Date: _____

Updated 2-13-15