



INDIANA UNIVERSITY

DIVISION OF CONTINUING MEDICAL EDUCATION

School of Medicine

PAYEE NAME:

PAYEE'S EMPLOYER:

EVENT TITLE:

PROJECT #:

DATE OF EVENT:

HONORARIUM

Disbursement Voucher Payee Certification

I hereby certify that the information relating to FIS (TP) Document Number _____
(to be completed by account manager) requesting payment for expenses is just and correct. I certify that all charges and/or reimbursements pertain to Indiana University business, that the amount is legally due after allowing all just credits and that no part of the same has previously been paid or will be paid by another source.

Amount of payment: \$ _____

Payee Signature (original signature required)

Date

Account Manager Signature

* Note: Attach original receipts, if appropriate.