



<http://www.csuci.edu/ira/index.htm>

Application
Instructionally Related Activities Funds Request
2008-2009 Academic Year
DEADLINE: Fall and Academic Year 3/14/08
Spring 10/15/08

Applications must first be sent to the appropriate program chair. Chairs will then recommend and route them to the Dean's Office for review and authorization. The Dean's Office will then forward them to the IRA Committee for consideration.

Activity Title: Creating a Digital Library of Local Complementary Health Practitioner Demonstrations

Project Sponsor/Staff (Name/Phone): Barbara Thorpe/ 437-8421

Activity/Event Date(s): Tuesdays, 9/2-11/18, 3-5:50 p.m.

Date Funding Needed By: September, 2008

****Please Note that for Fall Requests the earliest that you will be notified of funding availability will be early June 2008 and for Spring Requests early January 2009.**

Please check if any of the following apply to your IRA:

Equipment Purchase	Field Trip
Event	Participant data collection for public dissemination, i.e. interviews/surveys that result is a journal/poster session/newsletter
<input checked="" type="checkbox"/> IT Requirements	Risk Management Consultation
International Travel	Late Submission (Passed Deadlines: Fall 3/14, spring 10/15)
Space/OPC Requirements	
Infrastructure/Remodel	
Other _____	

Previously Funded: YES ☒ NO Yes, Request # _____

Does your proposal require IRB (Institutional Review Board) approval: Yes ☒ No

Assessment submitted for previously Funded Activity: YES ☒ NO

Academic Program or Center Name and Budget Code: **Nursing Budget Code #721**

Date of Submission: 3/14/08

Amount Requested: \$2250.00
(Should match item 2. E. on page 4)

Estimated Number of Students Participating: 40

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2008-2009 Academic Year

Conditions and Considerations

Equipment Purchase-If requesting large equipment, Project Sponsor must show proof of correspondence with OPC Administration. In addition, all other purchases must follow Procurement Guidelines

Events-Attach copy of Events and Facilities Use Request Form (Public Folders-Events & Facilities folder) Consider time frame for set-up and take down.

Participant Data Collection for Public Dissemination-If Project Sponsor proposes to conduct research with human participants then it may be subject to IRB (Institutional Review Board for the Protection of Human Subjects) review. It is the Project Sponsor's responsibility to inquire with the IRB prior to IRA application submission to determine if the project is exempt from IRB review so that funding is not delayed. Please indicate on the cover page if your project is exempt from IRB review.

Field Trip-If approved, Identified Risks of Participation and Release Agreement must be submitted for each student to the Program Office (Public Folders-HR Forms).

IT Requirements-Requires proof of correspondence and approval from IT Administration

International Travel-Requires International Travel application be submitted to Center for International Affairs.

Risk Management Consultation-Requires proof of correspondence with Risk Management.

Space/OPC Requirements, Infrastructure/Remodel-Requires proof of correspondence with OPC Administration.

Late Submission (Deadlines: Fall 3/14, Spring 10/15)-Requires explanation for emergency funding.

Fiscal Management: Project Sponsor's program will be responsible for all costs incurred over and above what is funded through the IRA award and will be responsible for seeing that any revenue that is intended to offset the amount of the IRA award is transferred accordingly.

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2008-2009 Academic Year

Requirements and Signatures

Please provide the following in your application:

1. **Brief Activity Description.** Describe the activity and its relationship to the educational objectives of the students' program or major. Expert complementary and alternative health (CAH) practitioners (8-10) will explain and demonstrate a variety of CAH therapies and practices to help students achieve 3 of 6 Nursing/Psychology 342 course objectives. The course is an upper division interdisciplinary general education course (C3b, E) satisfying the university writing requirement. Students will research and collect information on a CAH modality, reflect on a series of questions related to the modality, describe their reaction **following demonstration** of a CAH therapy/practice and analyze the practice or therapy using reputable, evidence-based literature to support their analysis.
2. **Relation to IRA to Course Offerings.** All IRAs must be integrally related to the formal instructional offerings of the University and must be associated with scheduled credit courses. Please list all classes that relate to the program proposed. The IRA request is integral to the fall, 2008 course offering: Nursing/Psychology 342, 3 units satisfying C3b, E, upper division GE and the university writing requirement.
3. **Activity Assessment.** Describe the assessment process and measures that the program will use to determine if it has attained its educational goals. **Please note a report will be due at the end of the semester.** Three of six course objectives will be assessed through reaction papers and a formal research paper detailing a selected CAH practice along with evidence supporting its use within one or more of the National Institutes for Health Center for Complementary and Alternative Medicine five categories following observation and demonstration of that practice/modality.
4. **Activity Budget.** Please enclose a complete detailed budget of the entire Activity **bold** specific items of requested IRA funding. (Page 4) We are requesting honoraria totaling \$2,250.00
5. **Sources of Activity Support.** Please list the other sources of funding, and additional support for the activity. CSUCI Instructional Technology department has been consulted with regard to videotaping 10 hours of CAH practitioner demonstrations during fall, 2008 and approval is indicated in attached email.
7. **Acknowledgment.** Project Sponsor and Program Chair acknowledge that they have reviewed and accepted the Conditions and Considerations detailed on page 2. Barbara Thorpe and Karen Jensen have read and accepted the Conditions and Considerations detailed on page 2 of the Application for IRA and have signed on the next page.

Signatures and Dates

<u>Barbara Shupe</u>	<u>3/14/08</u>
Project Sponsor	Date
<u>Karen Jensen</u>	<u>4/2/08</u>
Program Chair/Director	Date
<u>A. H. Veider</u>	<u>4/3/08</u>
Dean	

RECEIVED
MAR 14 2008
Dean's Office

Application
Instructionally Related Activities Funds Request
2008-2009 Academic Year

ACTIVITY BUDGET FOR 2008-2009

1. Operating Expense Budget

A. Supplies	_____
B. Vendor Printing	_____
C. In-State Travel	_____
D. Out-of-State Travel	_____
E. Equipment Rental	_____
F. Equipment Purchase	_____
G. Contracts/Independent Contractors	_____
H. Honorarium	<u>\$2,250.00 *</u>
I. OPC Chargeback	_____
J. Copier Chargeback	_____
K. Other (Please Specify)	_____
 TOTAL Expenses	 _____

2. Revenue

A. Course Fees	_____
B. Ticket Sales	_____
C. Out of Pocket Student Fees (exclusive of course fees)	_____
D. Additional Sources of funding (Please specify And indicate source)	<u>\$1,200.00 **</u> <u>Academic Technology Services has agreed to videotape the guest speakers and "decode" the digital product for student accessibility(see email approval/support)</u>

**E. Requested Allocation
from IRA**

Total Revenue	<u>\$3,450.00* **</u>
---------------	-----------------------

- * 8-10 guest speakers
- ** Videotaping of 1 hour per guest speaker totaling 10 hours for an accessible video clip library to be used for current and future classes with encoding at \$120 p.h.X10 hrs. totaling \$1200 provided by ATS budget.

From: "Tom.Emens" <Tom.Emens@csuci.edu>
Subject: **Re: IT support email requested**
Date: April 3, 2008 8:34:36 AM PDT
To: Barbara Thorpe Cartee <barbthorpe@roadrunner.com>
Cc: "Swanson, Judy" <Judy.Swanson@csuci.edu>

Good morning Barbara-

I only have one small edit on the proposal with regards to the name of our department:

Wherever you have **Instructional Technology department** , please replace with **Academic Technology Service (ATS)**.

As per our earlier conversation regarding the videotaping and online delivery of the lectures, the following applies.

Note that the price for transcription and captioning per hour of finished video is now \$120 instead of \$100.

Videography & editing:

Videotaping and final-cut editing will be done by Academic Technology Services (ATS) at no charge.

508 Accessibility Standards for media delivery:

Section 508 standard transcription and captions will need to be done by a 3rd party vendor. Virtually all standard video formats are supported (Flash, Quicktime, DVD, etc).

A budget line for this proposal must include \$120 per finished hour of video. ATS will coordinate such services as well as transfer of approved budget to vendor through appropriate channels.

Encoding and delivery:

Encoding and delivery of final videos will be done by Academic technology Services (ATS) at no charge.

Best-

Tom Emens

Multimedia Specialist • CSUCI Academic Technology
John Spoor Broome Library
One University Drive, Camarillo, CA 93012
tel) 805-437-8946 fax)805-437-8910
tom.emens@csuci.edu

On 4/2/08 6:01 PM, "Barbara Thorpe Cartee" <barbthorpe@roadrunner.com> wrote:

> Dear Tom, I know everyone is focused on Friday's big event but did you
> and Judy receive this proposal from me Wed. am?
> I'll call you and Judy Thursday as my chair is signing at 9 and I need
> to take it forward to the Dean as it is late.

> Thanks!
> Barbara
>
>
>
>
>

Application
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ACTIVITY BUDGET FOR 2008-2009

1. Operating Expense Budget

A. Supplies	_____
B. Vendor Printing	_____
C. In-State Travel	_____
D. Out-of-State Travel	_____
E. Equipment Rental	_____
F. Equipment Purchase	_____
G. Contracts/Independent Contractors	_____
H. Honorarium	\$2,250.00 *
I. OPC Chargeback	_____
J. Copier Chargeback	_____
K. Other (Please Specify) ATSdecoding	\$1,200.00 **
TOTAL Expenses	\$3,450.00

2. Revenue

A. Course Fees	_____
B. Ticket Sales	_____
C. Out of Pocket Student Fees (exclusive of course fees)	_____
D. Additional Sources of funding (Please specify And indicate source)	_____
	Academic Technology Services agreed to videotape the guest speakers (see email approval/support)
E. Requested Allocation from IRA	

Total Revenue \$3,450.00*

* 8-10 guest speakers

** Videotaping and decoding of 1 hour per guest speaker totaling 10 hours for an accessible video clip library to be used for current and future classes.

Devins, Mary

From: Emens, Tom
Sent: Thursday, May 01, 2008 7:56 AM
To: Thorpe, Barbara
Cc: Devins, Mary
Subject: Re: IRA Proposal needs modification
Importance: High

Good morning Barbara & Mary-

Yes-

The \$1200 is needed to make the videos accessible and will be paid to an outside vendor.

I would edit the proposal as follows:

K. Other (video captioning) \$1200

Best –

Tom Emens
Multimedia Specialist • CSUCI Academic Technology Services
John Spoor Broome Library
One University Drive, Camarillo, CA 93012
tel) 805-437-8946 fax)805-437-8910
tom.emens@csuci.edu

On 4/30/08 9:40 PM, "Thorpe, Barbara" <Barbara.Thorpe@csuci.edu> wrote:

Dear Tom, I've been out of town and email range in remote Utah/Arizona, just rec'd Mary's email and hope it's not too late for IRA comm. to review. Pls. see changes Mary suggested on the proposal. I'm assuming the \$1200 is for the contracting for the decoding we had discussed and that the support from IT is the actual videotaping labor and materials. If this is not your understanding, pls. call me at 377-9266 and I will change it. If ATS needs the \$1200 to go directly to their budget code, pls. send it to me and I will add it under the nursing budget string. Pls. copy Mary Devins as I have so she knows she can go ahead in providing the revised proposal to the review committee. Sorry for the mix-up!
Thank you!
Barbara

From: Devins, Mary
Sent: Friday, April 25, 2008 1:43 PM
To: Thorpe, Barbara
Subject: IRA Proposal needs modification

Barbara,

I spoke with Tom Emens today about your IRA proposal. I think that there was a bit of a misunderstanding. ATS is not paying the \$1200 to make the videos accessible from their budget. They were asking that your budget include a line item for this expense. If you would like IRA to fund the entire \$3450 cost to produce these videos, can you please revise your proposal to indicate this request?

The committee will be meeting on Thursday and would like to be able to vote on your proposal. So, if you could

5/1/2008

send me the revised version by Wednesday, I would appreciate it. Please let me know if you have any questions or need additional information.

Than you,

Mary Devins
Faculty Support Coordinator

CSU Channel Islands
One University Drive
Camarillo, CA 93012

(805) 437-3253

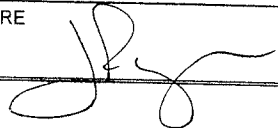
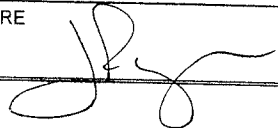
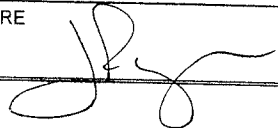
mary.devins@csuci.edu

PAYEE DATA RECORD**(Required in lieu of IRS W-9 when doing business with the State of California)**

STD 204 (Rev. 2-2000)

Note: Governmental Entities, federal, state, and local (including school districts) are not required to submit this form.

SECTION 1 must be completed by the requesting state agency before forwarding to the payee

1 PLEASE RETURN TO:	DEPARTMENT/OFFICE CSU Channel Islands STREET ADDRESS One University Drive CITY, STATE, ZIP CODE Camarillo, CA 93012 TELEPHONE NUMBER (805) 437-8400	PURPOSE: Information contained in this form will be used by state agencies to prepare Information Returns (Form 1099) and for withholding on payments to nonresident vendors. Prompt return of this fully completed form will prevent delays when processing payments. (See Privacy Statement on Page 2)						
2	PAYEE'S BUSINESS NAME T.C.R. Acupuncture & Integrative Medicine 2084 E. Ventura Blvd. MAILING ADDRESS (Number and Street or P.O. Box Number) (CITY, STATE, and ZIP CODE) Camarillo CA 93010							
3 PAYEE ENTITY INFORMATION	CHECK ONE BOX ONLY <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> LEGAL CORPORATION <input type="checkbox"/> MEDICAL CORPORATION <input type="checkbox"/> EXEMPT CORPORATION (Non-profit) <input type="checkbox"/> ALL OTHER CORPORATIONS FEDERAL EMPLOYER'S IDENTIFICATION NUMBER (FEIN) 1261-1013161912 </div> <div> <input checked="" type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST </div> </div> <div style="margin-top: 10px;"> <input type="checkbox"/> INDIVIDUAL SOLE PROPRIETOR SOCIAL SECURITY NUMBER [] [] [] - [] [] [] - [] [] [] [] OWNER'S FULL NAME </div>							
4 PAYEE RESIDENCY STATUS	CHECK APPROPRIATE BOX(ES) <input checked="" type="checkbox"/> California Resident - Qualified to do business in CA or a permanent place of business in CA. <input type="checkbox"/> Nonresident (See Page 2). Payments for services by nonresidents may be subject to state withholding. <input type="checkbox"/> WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED <input type="checkbox"/> SERVICES PERFORMED OUTSIDE OF CALIFORNIA							
5 CERTIFYING SIGNATURE	I hereby certify under penalty of perjury that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you. <table border="1" style="width: 100%;"> <tr> <td data-bbox="219 1816 868 1900"> AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) JULIE RYAN </td> <td data-bbox="868 1816 1161 1900"> TITLE OWNER </td> </tr> <tr> <td data-bbox="219 1900 868 1984"> SIGNATURE  </td> <td data-bbox="868 1900 1518 1984"> <table border="1" style="width: 100%;"> <tr> <td data-bbox="876 1900 1161 1984"> DATE 9/11/08 </td> <td data-bbox="1161 1900 1518 1984"> TELEPHONE NUMBER 805-388-6101 </td> </tr> </table> </td> </tr> </table>		AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) JULIE RYAN	TITLE OWNER	SIGNATURE 	<table border="1" style="width: 100%;"> <tr> <td data-bbox="876 1900 1161 1984"> DATE 9/11/08 </td> <td data-bbox="1161 1900 1518 1984"> TELEPHONE NUMBER 805-388-6101 </td> </tr> </table>	DATE 9/11/08	TELEPHONE NUMBER 805-388-6101
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257

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Than you,

Mary Devins
Faculty Support Coordinator

CSU Channel Islands
One University Drive
Camarillo, CA 93012

(805) 437-3253

mary.devins@csuci.edu

5/8/2008



California State University Channel Islands

Check Request Form

257

To be used for transactions other than employee travel or those requiring a purchase order or service agreement.

MAKE CHECK PAYABLE TO:

Name: TCR Accupuncture & Integrative Medicine

PeopleSoft Vendor ID: 5206

Note: New vendors must complete a Form 204

Address 1: 2084 E Ventura Blvd

Address 2: _____

City, State Zip: Camarillo, CA 93010

Check will be:

- ☐ Mailed to the address at left
☐ Picked up from Cashier - Ext _____

Description as it should appear on reports (30 characters)

Amount \$ 200.00

TYPE OF PAYMENT (Attach original receipts and invoice, if applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> Accreditation Fee | <input type="checkbox"/> Membership/Dues | <input type="checkbox"/> Postage |
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Non-Employee Reimb** | <input type="checkbox"/> Refund |
| <input type="checkbox"/> Freight/Shipping | <input type="checkbox"/> Parking/Bank Fee | <input type="checkbox"/> Registration Fee (w/ Travel Request) |
| <input checked="" type="checkbox"/> Honorarium/Speaker Fee(under 1K) | <input type="checkbox"/> Payroll Advance* | <input type="checkbox"/> Subscription/Periodical |
| <input type="checkbox"/> Interpreting/Notetaking Svc | <input type="checkbox"/> Permit/License Fee | <input type="checkbox"/> Utilities |
| <input type="checkbox"/> PO Closed *** | <input type="checkbox"/> Tax Remittance | <input type="checkbox"/> Sodexo (w/ Meal Approval Frm) |
| <input type="checkbox"/> CSU Overhead Costs | <input type="checkbox"/> Art Models | <input type="checkbox"/> Prizes/Awards (Non-General Fund) |
| <input type="checkbox"/> Lodging-Hampton/Country/Marriott (Camarillo only) | | <input checked="" type="checkbox"/> IRA Activity |

* To be used by payroll department only.

**Please attach a signed Non-Employee reimbursement form to this check request.

***To be used at year end only when PO on invoice has been closed and prior year funds have been reverted.

Description and/or explanation of payment.

Honorarium for speaker for IRA funded speaker series. See attached proposal. Vendor already in database.

☐ PLEASE SEND ATTACHED FORM WITH CHECK

CHARGE

Account	Fund	Dept ID	Program	Class	Project/Grant	Amount
613802	TK910	721	90221			\$200.00
Total						\$200.00

Requested Mary Devins x3253
Printed Name & Extension

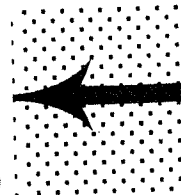
Mary Devins
Signature

9/18/08
Date

Approved by: Dan Wakelee
Printed Name

Dan Wakelee
Signature

9/22/08
Date





257
California State University Channel Islands
Check Request Form

To be used for transactions other than employee travel or those requiring a purchase order or service agreement.

MAKE CHECK PAYABLE TO:

Name: Melinda Froelich

Address 1: PO Box 1357

Address 2: _____

City, State Zip: Camarillo, CA 93011

PeopleSoft Vendor ID: 5185

Note: New vendors must complete a Form 204

Check will be:

☒ Mailed to the address at left

☐ Picked up from Cashier - Ext _____

Description as it should appear on reports (30 characters)

Honorarium - Melinda Froelich

Amount \$ 100.00

TYPE OF PAYMENT (Attach original receipts and invoice, if applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> Accreditation Fee | <input type="checkbox"/> Membership/Dues | <input type="checkbox"/> Postage |
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Non-Employee Reimb** | <input type="checkbox"/> Refund |
| <input type="checkbox"/> Freight/Shipping | <input type="checkbox"/> Parking/Bank Fee | <input type="checkbox"/> Registration Fee (w/ Travel Request) |
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**Please attach a signed Non-Employee reimbursement form to this check request.

***To be used at year end only when PO on invoice has been closed and prior year funds have been reverted.

Description and/or explanation of payment.

IRA event: Perspectives on Disability guest speaker on Sept 23rd, 2008. Vendor already in the system. IRA Proposal attached.

☐ PLEASE SEND ATTACHED FORM WITH CHECK

CHARGE

Account	Fund	Dept ID	Program	Class	Project/Grant	Amount
613802	TK910	745	90195			\$100.00
Total						\$100.00

Requested

Mary Devins

Printed Name & Extension

Mary Devins
Signature

1/9/09

Date

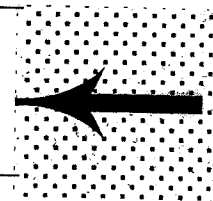
Approved by: Dan Wakelee, Associate Dean

Printed Name

Dan Wakelee
Signature

1/9/09

Date



Jan 21 09 02:40p

Barbara Thorpe

8054841010

p. 2

Jan-21-09 01:17P Henri G Boshoff DC
Sent via US Mailbox boshoff@thorpe

805 388-5570
 805 388-5570

P. 1

State of California—Department of Health Services

PAYEE DATA RECORD

(Required in lieu of IRS W-9 when doing business with the State of California)

STD 204 (Rev. 2-2000)

Note: Governmental Entities, federal, state, and local (including school districts) are not required to submit this form.

SECTION 1 must be completed by the requesting state agency before forwarding to the payee

1	DEPARTMENT/OFFICE CSU Channel Islands <hr/> STREET ADDRESS One University Drive <hr/> CITY, STATE, ZIP CODE Camarillo, CA 93012 <hr/> TELEPHONE NUMBER (805) 437-8400	PURPOSE: Information contained in this form will be used by state agencies to prepare Information Returns (Form 1099) and for withholding on payments to nonresident vendors. Prompt return of this fully completed form will prevent delays when processing payments. <i>(See Privacy Statement on Page 2)</i>	
2	PAYEE'S BUSINESS NAME NICOLAAS M. BOSHOFF <hr/> 3639 LAS POSAS RD #127 <hr/> MAILING ADDRESS (Number and Street or P.O. Box Number) CAMARILLO, CA 93010 <hr/> (CITY, STATE, and ZIP CODE)		
3	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> PAYEE ENTITY INFORMATION </div> <div style="width: 50%;"> CHECK ONE BOX ONLY <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> LEGAL CORPORATION <input type="checkbox"/> MEDICAL CORPORATION <input type="checkbox"/> EXEMPT CORPORATION (Non-profit) <input type="checkbox"/> ALL OTHER CORPORATIONS FEDERAL EMPLOYER'S IDENTIFICATION NUMBER (FEIN) <div style="border: 1px solid black; width: 100px; height: 1.2em; margin-top: 5px;"></div> </div> <div style="width: 48%;"> <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST </div> </div> </div> </div> <div style="margin-top: 10px;"> <input checked="" type="checkbox"/> INDIVIDUAL SOLE PROPRIETOR SOCIAL SECURITY NUMBER OWNER'S FULL NAME <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 157121-1711-152181 </div> <div style="width: 50%;"> NICOLAAS M. BOSHOFF </div> </div> </div>		NOTE: State and local governmental entities, including school districts are not required to submit this form. NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.
4	CHECK APPROPRIATE BOX(ES) <input checked="" type="checkbox"/> California Resident - Qualified to do business in CA or a permanent place of business in CA. <input type="checkbox"/> Nonresident (See Page 2). Payments for services by nonresidents may be subject to state withholding. <div style="margin-left: 20px;"> <input type="checkbox"/> WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED <input type="checkbox"/> SERVICES PERFORMED OUTSIDE OF CALIFORNIA </div>		NOTE: a. An estate is a resident if decedent was a California resident at time of death. b. A trust is a resident if at least one trustee is a California resident. <i>(See Page 2)</i>
5	I hereby certify under penalty of perjury that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you.		
CERTIFYING SIGNATURE	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> SIGNATURE </div>	TITLE DATE <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> 1-21-07 </div>	TELEPHONE NUMBER <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> 805-987-5450 </div>



257
California State University Channel Islands
Check Request Form

To be used for transactions not requiring a purchase order, service agreement or travel & expense reimbursement

MAKE CHECK PAYABLE TO:Name: Stephen Todd NedelevfAddress 1: 1791 Kendall Avenue

Address 2: _____

City, State Zip: Camarillo, CA 93010Amount: \$ 200.00

PeopleSoft Vendor ID: _____

Note: New vendors must complete a Form 204

Check Instructions:

- ☒ Mail to payee
☐ Pick up at Cashier - Ext _____
☐ Mail attachments with check – include copies

Description to appear on reports (30 characters)

Nedelevf Honorarium**TYPE OF PAYMENT:**

- | | | |
|--|--|--|
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Lodging (Camarillo area) ** | <input type="checkbox"/> Subscription/Periodical |
| <input type="checkbox"/> Art Model | <input type="checkbox"/> Membership/Dues | <input type="checkbox"/> Tax Remittance* |
| <input type="checkbox"/> Bank Fee* | <input type="checkbox"/> Parking | <input type="checkbox"/> Utility/Telephone |
| <input type="checkbox"/> Freight/Postage | <input type="checkbox"/> Payroll | <input checked="" type="checkbox"/> IRA Activity |
| <input checked="" type="checkbox"/> Honorarium/Speaker | <input type="checkbox"/> Permit/License | <input type="checkbox"/> Other- must be explained |
| <input type="checkbox"/> Interpreting/Note taking | <input type="checkbox"/> Registration/Conference | |

*Accounting Use Only

**Hampton Inn/Country Inn/Courtyard Marriott

DESCRIPTION AND/OR EXPLANATION OF PAYMENT:

244 form attached and previously faxed to Procurement. Speaker for IRA Funded "Creating a Digital Library of Local Complementary Health Practitioner Demonstrations". Offer letter and proposal attached.

ACCOUNTING & APPROVAL:

Account	Fund	Dept ID*	Program	Class	Project/Grant**	Amount
613802	TK910	721	90221			\$200.00
Total						\$200.00

*Depts. 2xx,3xx,4xx,6xx, require additional approval by VP Finance & Admin.; dept 9xx requires approval by Budget Dir.

**SA901 Grant requires additional review by Grants/Contracts Administrator

Requestor: Mary Devins x3253

Printed Name & Extension

Signature

Date

Approver: Dan Wakelee x8542

Printed Name & Extension

Signature

Date

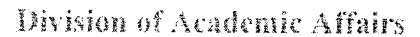
Approver:

(If required)

Printed Name & Extension

Signature

Date



257

State of California—Department of Health Services

PAYEE DATA RECORD

(Required in lieu of IRS W-9 when doing business with the State of California)

STD 204 (Rev. 2-2000)

Note: Governmental Entities, federal, state, and local (including school districts) are not required to submit this form.

SECTION 1 must be completed by the requesting state agency before forwarding to the payee

1 PLEASE RETURN TO:	DEPARTMENT/OFFICE CSU Channel Islands STREET ADDRESS One University Drive CITY, STATE, ZIP CODE Camarillo, CA 93012 TELEPHONE NUMBER (805) 437-8400	PURPOSE: Information contained in this form will be used by state agencies to prepare Information Returns (Form 1099) and for withholding on payments to nonresident vendors. Prompt return of this fully completed form will prevent delays when processing payments. (See Privacy Statement on Page 2)						
2	PAYEE'S BUSINESS NAME Stephen Todd Nedeleff 1791 Kendall Avenue MAILING ADDRESS (Number and Street or P.O. Box Number) Camarillo, CA 93010 (CITY, STATE, and ZIP CODE)							
3 PAYEE ENTITY INFORMATION	CHECK ONE BOX ONLY <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> LEGAL CORPORATION <input type="checkbox"/> MEDICAL CORPORATION <input type="checkbox"/> EXEMPT CORPORATION (Non-profit) <input type="checkbox"/> ALL OTHER CORPORATIONS FEDERAL EMPLOYER'S IDENTIFICATION NUMBER (FEIN) <div style="border: 1px solid black; width: 100px; height: 15px; margin-top: 5px;"></div> </div> <div style="width: 45%;"> <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST </div> </div> <input checked="" type="checkbox"/> INDIVIDUAL SOLE PROPRIETOR SOCIAL SECURITY NUMBER <div style="border: 1px solid black; padding: 2px; display: inline-block;">516015317659</div> OWNER'S FULL NAME Stephen Todd Nedeleff							
4 PAYEE RESIDENCY STATUS	CHECK APPROPRIATE BOX(ES) <input checked="" type="checkbox"/> California Resident - Qualified to do business in CA or a permanent place of business in CA. <input type="checkbox"/> Nonresident (See Page 2). Payments for services by nonresidents may be subject to state withholding. <div style="margin-top: 10px;"> <input type="checkbox"/> WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED <input type="checkbox"/> SERVICES PERFORMED OUTSIDE OF CALIFORNIA </div>							
5 CERTIFYING SIGNATURE	I hereby certify under penalty of perjury that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you. <table border="1" style="width: 100%;"> <tr> <td data-bbox="243 1785 860 1858"> AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) Stephen Todd Nedeleff </td> <td data-bbox="860 1785 1490 1858"> TITLE Owner </td> </tr> <tr> <td data-bbox="243 1858 860 1940"> SIGNATURE Stephen Todd Nedeleff </td> <td data-bbox="860 1858 1490 1940"> <table border="1" style="width: 100%;"> <tr> <td data-bbox="893 1858 1153 1940"> DATE 1/22/09 </td> <td data-bbox="1153 1858 1490 1940"> TELEPHONE NUMBER (805) 218-4054 </td> </tr> </table> </td> </tr> </table>		AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) Stephen Todd Nedeleff	TITLE Owner	SIGNATURE Stephen Todd Nedeleff	<table border="1" style="width: 100%;"> <tr> <td data-bbox="893 1858 1153 1940"> DATE 1/22/09 </td> <td data-bbox="1153 1858 1490 1940"> TELEPHONE NUMBER (805) 218-4054 </td> </tr> </table>	DATE 1/22/09	TELEPHONE NUMBER (805) 218-4054
AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) Stephen Todd Nedeleff	TITLE Owner							
SIGNATURE Stephen Todd Nedeleff	<table border="1" style="width: 100%;"> <tr> <td data-bbox="893 1858 1153 1940"> DATE 1/22/09 </td> <td data-bbox="1153 1858 1490 1940"> TELEPHONE NUMBER (805) 218-4054 </td> </tr> </table>	DATE 1/22/09	TELEPHONE NUMBER (805) 218-4054					
DATE 1/22/09	TELEPHONE NUMBER (805) 218-4054							



California State University Channel Islands
Check Request Form

257

To be used for transactions not requiring a purchase order, service agreement or travel & expense reimbursement

MAKE CHECK PAYABLE TO:

Name: Cassandra Severa

Address 1: 815 Calle La Roda

Address 2: _____

City, State Zip: Camarillo, CA 93010

Amount: \$ 200.00

PeopleSoft Vendor ID: _____

Note: New vendors must complete a Form 204

Check Instructions:

- ☒ Mail to payee
☐ Pick up at Cashier - Ext _____
☐ Mail attachments with check – include copies

Description to appear on reports (30 characters)

Severa Honorarium

TYPE OF PAYMENT:

- | | | |
|--|--|--|
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Lodging (Camarillo area) ** | <input type="checkbox"/> Subscription/Periodical |
| <input type="checkbox"/> Art Model | <input type="checkbox"/> Membership/Dues | <input type="checkbox"/> Tax Remittance* |
| <input type="checkbox"/> Bank Fee* | <input type="checkbox"/> Parking | <input type="checkbox"/> Utility/Telephone |
| <input type="checkbox"/> Freight/Postage | <input type="checkbox"/> Payroll | <input checked="" type="checkbox"/> IRA Activity |
| <input checked="" type="checkbox"/> Honorarium/Speaker | <input type="checkbox"/> Permit/License | <input type="checkbox"/> Other- <u>must</u> be explained |
| <input type="checkbox"/> Interpreting/Note taking | <input type="checkbox"/> Registration/Conference | |

*Accounting Use Only

**Hampton Inn/Country Inn/Courtyard Marriott

DESCRIPTION AND/OR EXPLANATION OF PAYMENT:

244 form attached and previously faxed to Procurement. Speaker for IRA Funded "Creating a Digital Library of Local Complementary Health Practitioner Demonstrations". Offer letter and proposal attached.

ACCOUNTING & APPROVAL:

Account	Fund	Dept ID*	Program	Class	Project/Grant**	Amount
613802	TK910	721	90221			\$200.00
Total						\$200.00

*Depts. 2xx,3xx,4xx,6xx, require additional approval by VP Finance & Admin.; dept 9xx requires approval by Budget Dir.

**SA901Grant requires additional review by Grants/Contracts Administrator

Requestor: Mary Devins x3253
Printed Name & Extension

Signature

Date

Approver: Dan Wakelee x8542
Printed Name & Extension

Signature

Date

Approver:
(If required) _____
Printed Name & Extension

Signature

Date



257

Division of Academic Affairs

November 10, 2008

Dear Ms. Severa,

Thank you for your willingness to offer your presentation on "Fitness: cardiovascular, strength, flexibility, stress management" on November 13, 2008 at CSU Channel Islands in Camarillo from 3-4:15 p.m. This letter is to formalize the invitation and to let you know the details of the event.

The class is part of an upper division general education course entitled "Complementary and Alternative Health" and is attended by 40 students from several disciplines, among them nursing, psychology, business and liberal studies. The class will be videotaped by Tom Emens in conjunction with an instructionally-related grant that will enable access for students who may not be able to attend a traditional class. The classroom is located in the Bell Tower West Building in Room 2505. We hope to begin promptly at 3 p.m. with a brief introduction of you to the 40 students and conclude at about 4:15 p.m.

We are pleased to offer you an honorarium of \$200 each in gratitude for your participation, and to cover any travel expenses. We will have a parking pass for you at the Public Safety Office, first building on the right as you enter campus with free parking in front labeled "Placer Hall." The officers will tell you which parking lots are best for Bell Tower 2505. Allow 25 minutes to find and walk to the classroom on the second floor.

If you have any information that you would like me to photocopy for the students to read, please email it to me as a word attachment at bthorpe@ymail.com. Please don't hesitate to call me if any issues arise. Thank you again for your willingness to share this exciting area of complementary health.

Sincerely,

Barbara Thorpe
Professor of Nursing

California State University Channel Islands
(805) 437-8821; C 805-377-9266
Barbara.thorpe@csuci.edu

Cc: Mary Devins

One University Drive, Camarillo, California 93012-8599 • Tel: (805) 437-XXXX • Fax: (805) 437-XXXX • www.csuci.edu

a campus of The California State University • Bakersfield • Channel Islands • Chico • Dominguez Hills • Fresno • Fullerton • Hayward • Humboldt • Long Beach • Los Angeles
Maritime Academy • Monterey Bay • Northridge • Pomona • Sacramento • San Bernardino • San Diego • San Francisco • San Jose • San Luis Obispo • San Marcos • Sonoma • Stanislaus

257

State of California—Department of Health Services

PAYEE DATA RECORD

(Required in lieu of IRS W-9 when doing business with the State of California)

STD 204 (Rev. 2-2000)

Note: Governmental Entities, federal, state, and local (including school districts) are not required to submit this form.

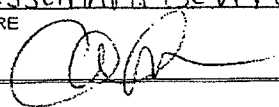
SECTION 1 must be completed by the requesting state agency before forwarding to the payee

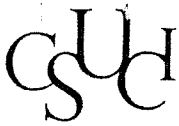
1 PLEASE RETURN TO:	DEPARTMENT/OFFICE CSU Channel Islands	PURPOSE: Information contained in this form will be used by state agencies to prepare Information Returns (Form 1099) and for withholding on payments to nonresident vendors. Prompt return of this fully completed form will prevent delays when processing payments. (See Privacy Statement on Page 2)
	STREET ADDRESS One University Drive	
	CITY, STATE, ZIP CODE Camarillo, CA 93012	
	TELEPHONE NUMBER (805) 437-8400	

2	PAYEE'S BUSINESS NAME <u>Cassandra Severa</u> <u>815 Calle La Roda</u> MAILING ADDRESS (Number and Street or P.O. Box Number) <u>Camarillo CA 93010</u> (CITY, STATE, and ZIP CODE)
----------	--

3 PAYEE ENTITY INFORMATION	CHECK ONE BOX ONLY <input type="checkbox"/> LEGAL CORPORATION <input type="checkbox"/> MEDICAL CORPORATION <input type="checkbox"/> EXEMPT CORPORATION (Non-profit) <input type="checkbox"/> ALL OTHER CORPORATIONS FEDERAL EMPLOYER'S IDENTIFICATION NUMBER (FEIN) [][]-[][][][][][][][][][] <input checked="" type="checkbox"/> INDIVIDUAL SOLE PROPRIETOR SOCIAL SECURITY NUMBER <u>15191-1611-1641712</u> OWNER'S FULL NAME <u>Cassandra Jean Severo-Preston</u>	NOTE: State and local governmental entities, including school districts are not required to submit this form. NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.
--	---	--

4 PAYEE RESIDENCY STATUS	CHECK APPROPRIATE BOX(ES) <input checked="" type="checkbox"/> California Resident - Qualified to do business in CA or a permanent place of business in CA. <input type="checkbox"/> Nonresident (See Page 2). Payments for services by nonresidents may be subject to state withholding. <input type="checkbox"/> WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED <input type="checkbox"/> SERVICES PERFORMED OUTSIDE OF CALIFORNIA	NOTE: a. An estate is a resident if decedent was a California resident at time of death. b. A trust is a resident if at least one trustee is a California resident. (See Page 2)
--	--	--

5 CERTIFYING SIGNATURE	I hereby certify under penalty of perjury that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you.		
	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) <u>Cassandra Severa</u>	TITLE <u>owner</u>	
	SIGNATURE 	DATE <u>1/22/09</u>	TELEPHONE NUMBER <u>(805) 216-4667</u>



California State University Channel Islands

Check Request Form

To be used for transactions other than employee travel or those requiring a purchase order or service agreement.

MAKE CHECK PAYABLE TO:

Name: Karen Osburn

Address 1: 3180 Willow Lane Ste 106

Address 2: _____

City, State Zip: Westlake Village, CA 91361

Amount \$ 200.00

PeopleSoft Vendor ID: _____

Note: New vendors must complete a Form 204

Check will be:

☒ Mailed to the address at left

☐ Picked up from Cashier - Ext _____

Description as it should appear on reports (30 characters)

TYPE OF PAYMENT (Attach original receipts and invoice, if applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> Accreditation Fee | <input type="checkbox"/> Membership/Dues | <input type="checkbox"/> Postage |
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Non-Employee Reimb** | <input type="checkbox"/> Refund |
| <input type="checkbox"/> Freight/Shipping | <input type="checkbox"/> Parking/Bank Fee | <input type="checkbox"/> Registration Fee (w/ Travel Request) |
| <input checked="" type="checkbox"/> Honorarium/Speaker Fee(under 1K) | <input type="checkbox"/> Payroll Advance* | <input type="checkbox"/> Subscription/Periodical |
| <input type="checkbox"/> Interpreting/Notetaking Svc | <input type="checkbox"/> Permit/License Fee | <input type="checkbox"/> Utilities |
| <input type="checkbox"/> PO Closed *** | <input type="checkbox"/> Tax Remittance | <input type="checkbox"/> Sodexo (w/ Meal Approval Frm) |
| <input type="checkbox"/> CSU Overhead Costs | <input type="checkbox"/> Art Models | <input type="checkbox"/> Prizes/Awards (Non-General Fund) |
| <input type="checkbox"/> Lodging-Hampton/Country/Marriott (Camarillo only) | | <input checked="" type="checkbox"/> IRA Activity |

* To be used by payroll department only.

**Please attach a signed Non-Employee reimbursement form to this check request.

***To be used at year end only when PO on invoice has been closed and prior year funds have been reverted.

Description and/or explanation of payment.

Honorarium for speaker for IRA funded speaker series. See attached proposal. Payee data form attached (was previously faxed to Procurement).

☐ PLEASE SEND ATTACHED FORM WITH CHECK

CHARGE

Account	Fund	Dept ID	Program	Class	Project/Grant	Amount
613802	TK910	721	90221			\$200.00
Total						\$200.00

Requested

Mary Devins x3253

Printed Name & Extension

Mary Devins
Signature

10/7/08

Date

Approved by:

Dan Wakelee

Printed Name

Dan Wakelee
Signature

10/7/08

Date

PAYEE DATA RECORD**(Required in lieu of IRS W-9 when doing business with the State of California)**

STD 204 (Rev. 2-2000)

Note: Governmental Entities, federal, state, and local (including school districts) are not required to submit this form.**SECTION 1** must be completed by the requesting state agency before forwarding to the payee**1****PLEASE
RETURN
TO:**

DEPARTMENT/OFFICE
CSU Channel Islands

STREET ADDRESS
One University Drive

CITY, STATE, ZIP CODE
Camarillo, CA 93012

TELEPHONE NUMBER
(805) 437-8400

PURPOSE: Information contained in this form will be used by state agencies to prepare Information Returns (Form 1099) and for withholding on payments to nonresident vendors. Prompt return of this fully completed form will prevent delays when processing payments.

*(See Privacy Statement on Page 2)***2****PAYEE'S BUSINESS NAME**

Kasen Osburn

3180 Willow Ln, Suite #106

MAILING ADDRESS (Number and Street or P.O. Box Number)

Westlake Village, CA 91361

(CITY, STATE, and ZIP CODE)**3****PAYEE
ENTITY
INFORMATION****CHECK ONE BOX ONLY**

- ☐ LEGAL CORPORATION
- ☐ MEDICAL CORPORATION
- ☐ EXEMPT CORPORATION (Non-profit)
- ☐ ALL OTHER CORPORATIONS
- FEDERAL EMPLOYER'S IDENTIFICATION NUMBER (FEIN)

- ☐ PARTNERSHIP
- ☐ ESTATE OR TRUST

NOTE: State and local governmental entities, including school districts are not required to submit this form.

☒ **INDIVIDUAL SOLE PROPRIETOR**

SOCIAL SECURITY NUMBER

OWNER'S FULL NAME

1516191-19141-91819121 Kasen Osburn

NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

4**PAYEE
RESIDENCY
STATUS****CHECK APPROPRIATE BOX(ES)**

- ☒ California Resident - Qualified to do business in CA or a permanent place of business in CA.
- ☐ Nonresident (See Page 2). Payments for services by nonresidents may be subject to state withholding.
- ☐ WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED
- ☐ SERVICES PERFORMED OUTSIDE OF CALIFORNIA

NOTE:

- a. An estate is a resident if decedent was a California resident at time of death.
- b. A trust is a resident if at least one trustee is a California resident.
- (See Page 2)*

5**CERTIFYING
SIGNATURE**

I hereby certify under penalty of perjury that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you.

AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)

Kasen Osburn

TITLE

SIGNATURE

Kasen Osburn

DATE

9/25/08

TELEPHONE NUMBER

(805) 368-3958

September 25, 2008

Dear Ms. Sterner,

Thank you again for your presentation on "Ayurvedic Medicine" on September 25, 2008. This letter is to formalize the invitation and to let you know the details of the event.

The class is part of an upper division general education course entitled "Complementary and Alternative Health" and is attended by 50 students from several disciplines, among them nursing, psychology, business and liberal studies. The class will be videotaped by Tom Emens in conjunction with an instructionally-related grant that will enable access for students who may not be able to attend a traditional class. The classroom is located in the Bell Tower West Building in Room 2505. We hope to begin promptly at 3 p.m. with a brief introduction of you to the 50 students and conclude at about 4:15 p.m.

We are pleased to offer you an honorarium of \$200 in gratitude for your participation, and to cover any travel expenses. We will have a parking pass for you at the Public Safety Office, first building on the right as you enter campus with free parking in front labeled "Placer Hall." The officers will tell you which parking lots are best for Bell Tower 2505.

Again, please don't hesitate to call me if any issues arise. Thank you again for your willingness to share this exciting area of complementary health.

Sincerely,

Barbara Thorpe
Professor of Nursing

California State University Channel Islands
(805) 437-8821; C 805-377-9266
Barbara.thorpe@csuci.edu

Cc: Mary Devins

257

TO: Mary Devins
FROM: Barbara Thorpe
DATE: November 3, 2008
SUBJECT: Request for \$150 budget augmentation for IRA #257 Creating a Digital Library project

I am requesting \$150 more in funding for guest speakers honoraria for the IRA #257 Digital Library Project. Our original line item was \$2250 based on 10 out of the 12 actually accepting and presenting. All twelve accepted. The additional \$150 would bring the total line item to \$2400 for guest speakers honoraria.

The reasons for the request follow:

- . All twelve (12) guest speakers were issued invitations in June and by September all had accepted our invitation, which is unusual.**
- . Thus far, eight (8) out of the 12 speakers have presented with no cancellations or no shows.**
- . The speakers have all been very well prepared and signed our Audio-visual release forms so that digitized material can be used broadly for the purposes of the grant.**

Should there be a last minute guest speaker cancellation or illness in November, we will not use the entire allocation and will return the unused balance.

Thank you for your consideration of this request



California State University Channel Islands
Check Request Form

257

To be used for transactions not requiring a purchase order, service agreement or travel & expense reimbursement

MAKE CHECK PAYABLE TO:

Name: Nicholas M Boshoff

Address 1: 3639 Las Posas Road #127

Address 2: _____

City, State Zip: Camarillo, CA 93010

Amount: \$ 200.00

PeopleSoft Vendor ID: _____

Note: New vendors must complete a Form 204

Check Instructions:

- ☒ Mail to payee
☐ Pick up at Cashier - Ext _____
☐ Mail attachments with check - include copies

Description to appear on reports (30 characters)

Boshoff Honorarium

TYPE OF PAYMENT:

- | | | |
|--|--|--|
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Lodging (Camarillo area) ** | <input type="checkbox"/> Subscription/Periodical |
| <input type="checkbox"/> Art Model | <input type="checkbox"/> Membership/Dues | <input type="checkbox"/> Tax Remittance* |
| <input type="checkbox"/> Bank Fee* | <input type="checkbox"/> Parking | <input type="checkbox"/> Utility/Telephone |
| <input type="checkbox"/> Freight/Postage | <input type="checkbox"/> Payroll | <input checked="" type="checkbox"/> IRA Activity |
| <input checked="" type="checkbox"/> Honorarium/Speaker | <input type="checkbox"/> Permit/License | <input type="checkbox"/> Other- <u>must</u> be explained |
| <input type="checkbox"/> Interpreting/Note taking | <input type="checkbox"/> Registration/Conference | |

*Accounting Use Only

**Hampton Inn/Country Inn/Courtyard Marriott

DESCRIPTION AND/OR EXPLANATION OF PAYMENT:

244 form attached and previously faxed to Procurement. Speaker for IRA Funded "Creating a Digital Library of Local Complementary Health Practitioner Demonstrations". Offer letter and proposal attached.

ACCOUNTING & APPROVAL:

Account	Fund	Dept ID*	Program	Class	Project/Grant**	Amount
613802	TK910	721	90221			\$200.00
Total						\$200.00

*Depts. 2xx,3xx,4xx,6xx, require additional approval by VP Finance & Admin.; dept 9xx requires approval by Budget Dir.

**SA901 Grant requires additional review by Grants/Contracts Administrator

Requestor: Mary Devins x3253
Printed Name & Extension

Mary Devins
Signature

1/22/09
Date

Approver: Dan Wakelee x8542
Printed Name & Extension

Dan Wakelee
Signature

1/23/09
Date

Approver:
(If required) _____
Printed Name & Extension

Signature

Date



September 11, 2008

Dear Ms. Petyak-Ryan,

Thank you again for your presentation on "Traditional Chinese Medicine" on September 11, 2008. This letter is to formalize the invitation and to let you know the details of the event.

The class is part of an upper division general education course entitled "Complementary and Alternative Health" and is attended by 53 students from several disciplines, among them nursing, psychology, business and liberal studies. The class will be videotaped by Tom Emens in conjunction with an instructionally-related grant that will enable access for students who may not be able to attend a traditional class. The classroom is located in the Bell Tower West Building in Room 2505. We hope to begin promptly at 3 p.m. with a brief introduction of you to the 53 students and conclude at about 4:15 p.m.

We are pleased to offer you an honorarium of \$200 in gratitude for your participation, and to cover any travel expenses. We will have a parking pass for you at the Public Safety Office, first building on the right as you enter campus with free parking in front. The officers will tell you which parking lots are best for Bell Tower 2505.

Again, please don't hesitate to call me if any issues arise. Thank you again for your willingness to share this exciting area of complementary health.

Sincerely,

Barbara Thorpe
Professor of Nursing

California State University Channel Islands
(805) 437-8821; C 805-377-9266
Barbara.thorpe@csuci.edu

Cc: Mary Devins

NRS/PSY 342 List of Guest Speakers
(in order of appearance)

- 1 ✓ Julie Petyak-Ryan, MS., L.Ac
2084 E. Ventura Blvd.
Camarillo, CA. 93010
O 805-388-6101
F 805-388-6103
ryanjuli@gmail.com
- 2 ✓ George Lamoureux
Los Angeles, CA.
C-323-385-5464
gjlamoureux@earthlink.net
- 3 ✓ Karen Sterner (Osburn)
Clinical Ayurvedic Specialist
Westlake Holistic
3180 Willow Lane Suite 106
Westlake Village, CA. 91361
C-805-358-3958
- 4 ✓ Julie Tumamait #3296
365 N. Poli Ave.
Ojai, CA. 93023
O-805-646-6214
jtumamait@hotmail.com
- 5 ✓ Dr. Montano
Doctor of Naturopathy
529 S. A Street
Oxnard, CA. 93030
O-805-822-5160
cmontano@drcmontano.com
- 6 Dr. Richard Hiltner
Doctor of Homeopathy
169 E. El Roblar
Ojai, Ca. 93023
O-805-646-1495
rhiltner@sbc.global.net
- 7 Francie Broughton
francieB2@hotmail.com

8 Cassie Severa
AFAA
815 Calle La Roda
Camarillo, CA. 93010
C-805-216-4667
cassiesevera@gmail.com

9 Todd Nedelev
AFTA, BS Kinesiology
815 Calle La Roda
Camarillo, CA, 93010
C-805-218-4054
toddnedelev@gmail.com

10 Nick Boshoff
Doctor of Chiropractic
3639 Las Posas Road. #127
Camarillo, CA. 93010
O-805-987-5450
nickb@cipcug.org

11 Special consultants:
Dr. Kevin Volkan
Kevin.volkan@csuci.edu

12 Dr. Kimmey Kee Rose
Kimmeykee.rose@csuci.edu

257



Visual/Audio Image Release Form

I grant permission to California State University, its employees and agents, to take and use visual/audio images of me. Visual/audio images are any type of recording, including but not limited to photographs, digital images, drawings, renderings, voices, sounds, video recordings, audio clips or accompanying written descriptions. CSU will not materially alter the original images. I agree that CSU owns the images and all rights related to them. The images may be used in any manner or media without notifying me, such as university-sponsored web sites, publications, promotions, broadcasts, advertisements, posters and theater slides, as well as for any non-university uses. I waive any right to inspect or approve the finished images or any printed or electronic matter that may be used with them, or to be compensated for them.

I release CSU and its employees and agents, including any firm authorized to publish and/or distribute a finished product containing the images, from any claims, damages or liability which I may ever have in connection with the taking of use of the images or printed material used within the images.

I am at least 18 years of age and competent to sign this release. I have read this release before signing, I understand its contents, meaning and impact and I freely accept the terms.

Kasen Osborn
Printed Name

9/25/08
Date

Kasen Osborn
Signature

1KasenOsborn@gmail.com
Email Address (optional)

Parent or Guardian if under 18 years of age

Address (optional)

Project:



VISUAL/AUDIO IMAGE RELEASE FORM

I GRANT PERMISSION TO CALIFORNIA STATE UNIVERSITY, ITS EMPLOYEES AND AGENTS, TO TAKE AND USE VISUAL/AUDIO IMAGES OF ME. VISUAL/AUDIO IMAGES ARE ANY TYPE OF RECORDING, INCLUDING BUT NOT LIMITED TO PHOTOGRAPHS, DIGITAL IMAGES, DRAWINGS, RENDERINGS, VOICES, SOUNDS, VIDEO RECORDINGS, AUDIO CLIPS OR ACCOMPANYING WRITTEN DESCRIPTIONS. CSU WILL NOT MATERIALLY ALTER THE ORIGINAL IMAGES. I AGREE THAT CSU OWNS THE IMAGES AND ALL RIGHTS RELATED TO THEM. THE IMAGES MAY BE USED IN ANY MANNER OR MEDIA WITHOUT NOTIFYING ME, SUCH AS UNIVERSITY-SPONSORED WEB SITES, PUBLICATIONS, PROMOTIONS, BROADCASTS, AUTHORIZED TO PUBLISH AND/OR DISTRIBUTE A FINISHED PRODUCT, ADVERTISEMENTS, POSTERS AND THEATER SLIDES, AS WELL AS FOR ANY CONTAINING THE IMAGES, FROM ANY CLAIMS, DAMAGES OR LIABILITY NON-UNIVERSITY SUES. I WAIVE ANY RIGHT TO INSPECT OR APPROVE THE WHICH I MAY EVER HAVE IN CONNECTION WITH THE TAKING OF USE OF FINISHED IMAGES OR ANY PRINTED OR ELECTRONIC MATTER THAT MAY BE USED WITH THEM, OR TO BE COMPENSATED FOR THEM. I HAVE READ THIS RELEASE BEFORE SIGNING, I UNDERSTAND ITS CONTENTS, MEANING AND IMPACT AND I FREELY ACCEPT THE TERMS.

Julie Tumamait

PRINTED NAME

DATE

10/2/88

Julie Tumamait

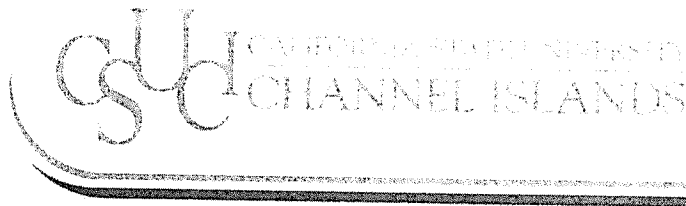
SIGNATURE

EMAIL ADDRESS (OPTIONAL)

PARENT OR GUARDIAN IF UNDER 18 YEARS OF AGE
(OPTIONAL)

ADDRESS

PROJECT:



257

November 3, 2008

Dear Ms. Broughton,

Thank you for your willingness to offer your presentation on "Yoga" on November 6, 2008 at CSU Channel Islands in Camarillo from 3-4:15 p.m. This letter is to formalize the invitation and to let you know the details of the event.

The class is part of an upper division general education course entitled "Complementary and Alternative Health" and is attended by 50 students from several disciplines, among them nursing, psychology, business and liberal studies. The class will be videotaped by Tom Emens in conjunction with an instructionally-related grant that will enable access for students who may not be able to attend a traditional class. The classroom is located in the Bell Tower West Building in Room 2505. We hope to begin promptly at 3 p.m. with a brief introduction of you to the 50 students and conclude at about 4:15 p.m.

We are pleased to offer you an honorarium of \$200 in gratitude for your participation, and to cover any travel expenses. **Attached find the Payee Data Record and AudioVisual Release forms for your completion.** We will have a parking pass for you at the Public Safety Office, first building on the right as you enter campus with free parking in front labeled "Placer Hall." The officers will tell you which parking lots are best for Bell Tower 2505. Allow 15 minutes to find and walk to the classroom on the second floor.

I have given you Chapter 15 on Yoga that the students will have read. Please don't hesitate to call me if any issues arise. Thank you again for your willingness to share this exciting area of complementary health.

Sincerely,

Barbara Thorpe
Professor of Nursing

California State University Channel Islands
(805) 437-8821; C 805-377-9266
Barbara.thorpe@csuci.edu

Cc: Mary Devins

257

September 12, 2008

Dear Mr. Lamoureux,

Thank you again for your presentation on "Herbs and Traditional Chinese Medicine" on September 18, 2008. This letter is to formalize the invitation and to let you know the details of the event.

The class is part of an upper division general education course entitled "Complementary and Alternative Health" and is attended by 50 students from several disciplines, among them nursing, psychology, business and liberal studies. The class will be videotaped by Tom Emens in conjunction with an instructionally-related grant that will enable access for students who may not be able to attend a traditional class. The classroom is located in the Bell Tower West Building in Room 2505. We hope to begin promptly at 3 p.m. with a brief introduction of you to the 50 students and conclude at about 4:15 p.m.

We are pleased to offer you an honorarium of \$200 in gratitude for your participation, and to cover any travel expenses. We will have a parking pass for you at the Public Safety Office, first building on the right as you enter campus with free parking in front labeled "Placer Hall." The officers will tell you which parking lots are best for Bell Tower 2505.

Again, please don't hesitate to call me if any issues arise. Thank you again for your willingness to share this exciting area of complementary health.

Sincerely,

Barbara Thorpe
Professor of Nursing

California State University Channel Islands
(805) 437-8821; C 805-377-9266
Barbara.thorpe@csuci.edu

Cc: Mary Devins



California State University Channel Islands

Check Request Form

To be used for transactions other than employee travel or those requiring a purchase order or service agreement.

257

MAKE CHECK PAYABLE TO:

Name: Jing Company Inc

Address 1: 533 S Los Angeles St

Address 2: Suite 502

City, State Zip: Los Angeles, CA 90013

PeopleSoft Vendor ID: _____

Note: New vendors must complete a Form 204

Check will be:

- ☒ Mailed to the address at left
☐ Picked up from Cashier - Ext _____

Description as it should appear on reports (30 characters)

Amount \$ 200.00

TYPE OF PAYMENT (Attach original receipts and invoice, if applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> Accreditation Fee | <input type="checkbox"/> Membership/Dues | <input type="checkbox"/> Postage |
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Non-Employee Reimb** | <input type="checkbox"/> Refund |
| <input type="checkbox"/> Freight/Shipping | <input type="checkbox"/> Parking/Bank Fee | <input type="checkbox"/> Registration Fee (w/ Travel Request) |
| <input checked="" type="checkbox"/> Honorarium/Speaker Fee(under 1K) | <input type="checkbox"/> Payroll Advance* | <input type="checkbox"/> Subscription/Periodical |
| <input type="checkbox"/> Interpreting/Notetaking Svc | <input type="checkbox"/> Permit/License Fee | <input type="checkbox"/> Utilities |
| <input type="checkbox"/> PO Closed *** | <input type="checkbox"/> Tax Remittance | <input type="checkbox"/> Sodexo (w/ Meal Approval Frm) |
| <input type="checkbox"/> CSU Overhead Costs | <input type="checkbox"/> Art Models | <input type="checkbox"/> Prizes/Awards (Non-General Fund) |
| <input type="checkbox"/> Lodging-Hampton/Country/Marriott (Camarillo only) | | <input checked="" type="checkbox"/> IRA Activity |

* To be used by payroll department only.

**Please attach a signed Non-Employee reimbursement form to this check request.

***To be used at year end only when PO on invoice has been closed and prior year funds have been reverted.

Description and/or explanation of payment.

Honorarium for speaker for IRA funded speaker series. See attached proposal. Payee data form attached (was previously faxed to Procurement).

☐ PLEASE SEND ATTACHED FORM WITH CHECK

CHARGE

Account	Fund	Dept ID	Program	Class	Project/Grant	Amount
613802	TK910	721	90221			\$200.00
Total						\$200.00

Requested Mary Devins x3253
Printed Name & Extension

Mary Devins 10/1/08
Signature Date

Approved by: Dan Wakelee
Printed Name

Dan Wakelee 10/1/08
Signature Date




PAYEE DATA RECORD**(Required in lieu of IRS W-9 when doing business with the State of California)**

STD 204 (Rev. 2-2000)

257

Note: Governmental Entities, federal, state, and local (including school districts) are not required to submit this form.

SECTION 1 must be completed by the requesting state agency before forwarding to the payee.

1 PLEASE RETURN TO:	DEPARTMENT/OFFICE CSU Channel Islands <hr/> STREET ADDRESS One University Drive <hr/> CITY, STATE, ZIP CODE Camarillo, CA 93012 <hr/> TELEPHONE NUMBER (805) 437-8400	PURPOSE: Information contained in this form will be used by state agencies to prepare Information Returns (Form 1099) and for withholding on payments to nonresident vendors. Prompt return of this fully completed form will prevent delays when processing payments. <i>(See Privacy Statement on Page 2)</i>								
2	PAYEE'S BUSINESS NAME <u>JING COMPANY, INC.</u> <hr/> <u>533 S. LOS ANGELES ST, SUITE 502,</u> <hr/> MAILING ADDRESS (Number and Street or P.O. Box Number) <u>LA CA 90013</u> <hr/> (CITY, STATE, and ZIP CODE)									
3 PAYEE ENTITY INFORMATION	CHECK ONE BOX ONLY <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> LEGAL CORPORATION <input type="checkbox"/> MEDICAL CORPORATION <input type="checkbox"/> EXEMPT CORPORATION (Non-profit) <input type="checkbox"/> ALL OTHER CORPORATIONS FEDERAL EMPLOYER'S IDENTIFICATION NUMBER (FEIN) <div style="border: 1px solid black; width: 100px; height: 15px; margin-top: 5px;"></div> </div> <div> <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST </div> </div> <hr/> <input type="checkbox"/> INDIVIDUAL SOLE PROPRIETOR SOCIAL SECURITY NUMBER OWNER'S FULL NAME <u>* 10143-14161-141618191</u> <u>George J. Lamoreaux</u>	NOTE: State and local governmental entities, including school districts are not required to submit this form. NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.								
4 PAYEE RESIDENCY STATUS	CHECK APPROPRIATE BOX(ES) <input type="checkbox"/> California Resident - Qualified to do business in CA or a permanent place of business in CA. <input type="checkbox"/> Nonresident (See Page 2). Payments for services by nonresidents may be subject to state withholding. <input type="checkbox"/> WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED <input type="checkbox"/> SERVICES PERFORMED OUTSIDE OF CALIFORNIA	NOTE: a. An estate is a resident if decedent was a California resident at time of death. b. A trust is a resident if at least one trustee is a California resident. <i>(See Page 2)</i>								
5 CERTIFYING SIGNATURE	<p><i>I hereby certify under penalty of perjury that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you.</i></p> <table border="1" style="width: 100%;"> <tr> <td colspan="2" data-bbox="253 1755 902 1839"> AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) </td> <td colspan="2" data-bbox="902 1755 1524 1839"> TITLE </td> </tr> <tr> <td data-bbox="253 1839 902 1913"> SIGNATURE  </td> <td data-bbox="902 1839 1179 1913"> DATE <u>9.18.8</u> </td> <td colspan="2" data-bbox="1179 1839 1524 1913"> TELEPHONE NUMBER <u>213-873-4488</u> </td> </tr> </table>		AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)		TITLE		SIGNATURE 	DATE <u>9.18.8</u>	TELEPHONE NUMBER <u>213-873-4488</u>	
AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print)		TITLE								
SIGNATURE 	DATE <u>9.18.8</u>	TELEPHONE NUMBER <u>213-873-4488</u>								



California State University Channel Islands

Check Request Form

To be used for transactions other than employee travel or those requiring a purchase order or service agreement.

MAKE CHECK PAYABLE TO:

Name: Richard Hiltner, MD

Address 1: 169 E. El Rublar Dr

Address 2: _____

City, State Zip: Ojai, CA 93023

Amount \$ 200.00

PeopleSoft Vendor ID: 257

Note: New vendors must complete a Form 204

Check will be:

- ☒ Mailed to the address at left
☐ Picked up from Cashier - Ext _____

Description as it should appear on reports (30 characters)

Hiltner Honorarium

TYPE OF PAYMENT (Attach original receipts and invoice, if applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> Accreditation Fee | <input type="checkbox"/> Membership/Dues | <input type="checkbox"/> Postage |
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Non-Employee Reimb** | <input type="checkbox"/> Refund |
| <input type="checkbox"/> Freight/Shipping | <input type="checkbox"/> Parking/Bank Fee | <input type="checkbox"/> Registration Fee (w/ Travel Request) |
| <input checked="" type="checkbox"/> Honorarium/Speaker Fee(under 1K) | <input type="checkbox"/> Payroll Advance* | <input type="checkbox"/> Subscription/Periodical |
| <input type="checkbox"/> Interpreting/Notetaking Svc | <input type="checkbox"/> Permit/License Fee | <input type="checkbox"/> Utilities |
| <input type="checkbox"/> PO Closed *** | <input type="checkbox"/> Tax Remittance | <input type="checkbox"/> Sodexo (w/ Meal Approval Frm) |
| <input type="checkbox"/> CSU Overhead Costs | <input type="checkbox"/> Art Models | <input type="checkbox"/> Prizes/Awards (Non-General Fund) |
| <input type="checkbox"/> Lodging-Hampton/Country/Marriott (Camarillo only) | | <input checked="" type="checkbox"/> IRA Activity |

* To be used by payroll department only.

**Please attach a signed Non-Employee reimbursement form to this check request.

***To be used at year end only when PO on invoice has been closed and prior year funds have been reverted.

Description and/or explanation of payment.

Honorarium for speaker for IRA funded speaker series. See attached proposal. 204 form attached - was previously faxed to procurement.

☐ PLEASE SEND ATTACHED FORM WITH CHECK

CHARGE

Account	Fund	Dept ID	Program	Class	Project/Grant	Amount
613802	TK910	721	90221			\$200.00
Total						\$200.00

Requested

Mary Devins x3253

Printed Name & Extension

Signature

10/20/08

Date

Approved by:

Dan Wakelee

Printed Name

Signature

10/21/08

Date

PAYEE DATA RECORD

(Required in lieu of IRS W-9 when doing business with the State of California)

STD 204 (Rev. 2-2000)

257

Note: Governmental Entities, federal, state, and local (including school districts) are not required to submit this form.

SECTION 1 must be completed by the requesting state agency before forwarding to the payee

1 PLEASE RETURN TO:	DEPARTMENT/OFFICE CSU Channel Islands STREET ADDRESS One University Drive CITY, STATE, ZIP CODE Camarillo, CA 93012 TELEPHONE NUMBER (805) 437-8400	PURPOSE: Information contained in this form will be used by state agencies to prepare Information Returns (Form 1099) and for withholding on payments to nonresident vendors. Prompt return of this fully completed form will prevent delays when processing payments. (See Privacy Statement on Page 2)								
2	PAYEE'S BUSINESS NAME <u>RICHARD HILTNER M.D.</u> <u>169 E. EL RUBLAR DR</u> MAILING ADDRESS (Number and Street or P.O. Box Number) <u>OTA, CA 93023</u> (CITY, STATE, and ZIP CODE)									
3 PAYEE ENTITY INFORMATION	CHECK ONE BOX ONLY <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> LEGAL CORPORATION <input checked="" type="checkbox"/> MEDICAL CORPORATION <input type="checkbox"/> EXEMPT CORPORATION (Non-profit) <input type="checkbox"/> ALL OTHER CORPORATIONS FEDERAL EMPLOYER'S IDENTIFICATION NUMBER (FEIN) <div style="border: 1px solid black; width: 100px; height: 15px; margin-top: 5px;"></div> </div> <div> <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST </div> </div> <input type="checkbox"/> INDIVIDUAL SOLE PROPRIETOR SOCIAL SECURITY NUMBER OWNER'S FULL NAME <u>14917-1461-14423</u> <u>RICHARD E. HILTNER</u>									
4 PAYEE RESIDENCY STATUS	CHECK APPROPRIATE BOX(ES) <input checked="" type="checkbox"/> California Resident - Qualified to do business in CA or a permanent place of business in CA. <input type="checkbox"/> Nonresident (See Page 2). Payments for services by nonresidents may be subject to state withholding. <div style="margin-top: 10px;"> <input type="checkbox"/> WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED <input type="checkbox"/> SERVICES PERFORMED OUTSIDE OF CALIFORNIA </div>									
5 CERTIFYING SIGNATURE	<p>I hereby certify under penalty of perjury that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you.</p> <table border="1" style="width: 100%;"> <tr> <td colspan="2" style="height: 40px; vertical-align: bottom;"> AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) <u>RICHARD HILTNER</u> </td> <td colspan="2" style="height: 40px; vertical-align: bottom;"> TITLE <u>PRESIDENT</u> </td> </tr> <tr> <td style="width: 50%; height: 40px; vertical-align: bottom;"> SIGNATURE </td> <td style="width: 20%; height: 40px; vertical-align: bottom;"> DATE <u>10/9/08</u> </td> <td colspan="2" style="height: 40px; vertical-align: bottom;"> TELEPHONE NUMBER <u>805 646 1495</u> </td> </tr> </table>		AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) <u>RICHARD HILTNER</u>		TITLE <u>PRESIDENT</u>		SIGNATURE 	DATE <u>10/9/08</u>	TELEPHONE NUMBER <u>805 646 1495</u>	
AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) <u>RICHARD HILTNER</u>		TITLE <u>PRESIDENT</u>								
SIGNATURE 	DATE <u>10/9/08</u>	TELEPHONE NUMBER <u>805 646 1495</u>								

PAYEE DATA RECORD

(Required in lieu of IRS W-9 when doing business with the State of California)

STD 204 (Rev. 2-2000)

Note: Governmental Entities, federal, state, and local (including school districts) are not required to submit this form.

SECTION 1 must be completed by the requesting state agency before forwarding to the payee

1	DEPARTMENT/OFFICE CSU Channel Islands <hr/> STREET ADDRESS One University Drive <hr/> CITY, STATE, ZIP CODE Camarillo, CA 93012 <hr/> TELEPHONE NUMBER (805) 437-8400	PURPOSE: Information contained in this form will be used by state agencies to prepare Information Returns (Form 1099) and for withholding on payments to nonresident vendors. Prompt return of this fully completed form will prevent delays when processing payments. (See Privacy Statement on Page 2)
2	PAYEE'S BUSINESS NAME <u>CUAHTEMOC MONTANO</u> <hr/> <u>539 S. A ST</u> <hr/> MAILING ADDRESS (Number and Street or P.O. Box Number) <u>OXNARD, CA 93030</u> <hr/> (CITY, STATE, and ZIP CODE)	
3	CHECK ONE BOX ONLY <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <input type="checkbox"/> LEGAL CORPORATION <input type="checkbox"/> MEDICAL CORPORATION <input type="checkbox"/> EXEMPT CORPORATION (Non-profit) <input type="checkbox"/> ALL OTHER CORPORATIONS FEDERAL EMPLOYER'S IDENTIFICATION NUMBER (FEIN) <div style="border: 1px solid black; width: 100px; height: 15px; margin-top: 5px;"></div> </div> <div style="width: 48%;"> <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST </div> </div> <div style="margin-top: 10px;"> <input checked="" type="checkbox"/> INDIVIDUAL SOLE PROPRIETOR SOCIAL SECURITY NUMBER <u>61231-021-3080</u> </div> <div style="margin-top: 5px;"> OWNER'S FULL NAME <u>CUAHTEMOC MONTANO</u> </div>	NOTE: State and local governmental entities, including school districts are not required to submit this form. NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.
4	CHECK APPROPRIATE BOX(ES) <input checked="" type="checkbox"/> California Resident - Qualified to do business in CA or a permanent place of business in CA. <input type="checkbox"/> Nonresident (See Page 2). Payments for services by nonresidents may be subject to state withholding. <div style="margin-top: 10px;"> <input type="checkbox"/> WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED <input type="checkbox"/> SERVICES PERFORMED OUTSIDE OF CALIFORNIA </div>	NOTE: a. An estate is a resident if decedent was a California resident at time of death. b. A trust is a resident if at least one trustee is a California resident. (See Page 2)
5	I hereby certify under penalty of perjury that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you.	
CERTIFYING SIGNATURE	AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) <u>CUAHTEMOC MONTANO</u> <hr/> SIGNATURE 	TITLE <u>Owner</u> <hr/> DATE <u>10/16/08</u> <hr/> TELEPHONE NUMBER <u>800-454-2829</u>



California State University Channel Islands

Check Request Form

To be used for transactions other than employee travel or those requiring a purchase order or service agreement.

MAKE CHECK PAYABLE TO:

Name: Cuauhtemoc Montano

Address 1: 539 S A St

Address 2: _____

City, State Zip: Oxnard, CA 93030

PeopleSoft Vendor ID: _____

Note: New vendors must complete a Form 204

Check will be:

- ☐ Mailed to the address at left
☐ Picked up from Cashier - Ext _____

Description as it should appear on reports (30 characters)

Amount \$ 200.00

TYPE OF PAYMENT (Attach original receipts and invoice, if applicable)

- | | | |
|--|---|---|
| <input type="checkbox"/> Accreditation Fee | <input type="checkbox"/> Membership/Dues | <input type="checkbox"/> Postage |
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Non-Employee Reimb** | <input type="checkbox"/> Refund |
| <input type="checkbox"/> Freight/Shipping | <input type="checkbox"/> Parking/Bank Fee | <input type="checkbox"/> Registration Fee (w/ Travel Request) |
| <input checked="" type="checkbox"/> Honorarium/Speaker Fee(under 1K) | <input type="checkbox"/> Payroll Advance* | <input type="checkbox"/> Subscription/Periodical |
| <input type="checkbox"/> Interpreting/Notetaking Svc | <input type="checkbox"/> Permit/License Fee | <input type="checkbox"/> Utilities |
| <input type="checkbox"/> PO Closed *** | <input type="checkbox"/> Tax Remittance | <input type="checkbox"/> Sodexo (w/ Meal Approval Frm) |
| <input type="checkbox"/> CSU Overhead Costs | <input type="checkbox"/> Art Models | <input type="checkbox"/> Prizes/Awards (Non-General Fund) |
| <input type="checkbox"/> Lodging-Hampton/Country/Marriott (Camarillo only) | | <input checked="" type="checkbox"/> IRA Activity |

* To be used by payroll department only.

**Please attach a signed Non-Employee reimbursement form to this check request.

***To be used at year end only when PO on invoice has been closed and prior year funds have been reverted.

Description and/or explanation of payment.

Honorarium for speaker for IRA funded speaker series. See attached proposal & offer letter. 204 Form attached, was previously faxed to Procurement.

☐ PLEASE SEND ATTACHED FORM WITH CHECK

CHARGE

Account	Fund	Dept ID	Program	Class	Project/Grant	Amount
613802	TK910	721	90221			\$200.00
Total						\$200.00

Requested

Mary Devins x3253

Printed Name & Extension

Signature

10/20/08

Date

Approved by:

Dan Wakelee

Printed Name

Signature

Date



California State University Channel Islands

Check Request Form

257

To be used for transactions not requiring a purchase order, service agreement or travel & expense reimbursement

MAKE CHECK PAYABLE TO:

Name: Michael Jensen, MD

Address 1: 610 Auburn Ave

Address 2:

City, State Zip: Sierra Madre, CA 91024

Amount: \$ 1000.00

*Check will only be held for 48 hours after notification before being mailed out.

PeopleSoft Vendor ID:

Note: New vendors must complete a Form 204

Check Instructions:

- ☐ Mail to payee
☒ * Pick up at Cashier - Ext 3253
☐ Mail attachments with check - include copies

Description to appear on reports (30 characters)

Jensen Honorarium

TYPE OF PAYMENT:

- | | | |
|--|--|--|
| <input type="checkbox"/> Advertising | <input type="checkbox"/> Lodging (Camarillo area) ** | <input type="checkbox"/> Subscription/Periodical |
| <input type="checkbox"/> Art Model | <input type="checkbox"/> Membership/Dues | <input type="checkbox"/> Tax Remittance* |
| <input type="checkbox"/> Bank Fee* | <input type="checkbox"/> Parking | <input type="checkbox"/> Utility/Telephone |
| <input type="checkbox"/> Freight/Postage | <input type="checkbox"/> Payroll | |
| <input checked="" type="checkbox"/> Honorarium/Speaker | <input type="checkbox"/> Permit/License | <input checked="" type="checkbox"/> IRA Activity |
| <input type="checkbox"/> Interpreting/Note taking | <input type="checkbox"/> Registration/Conference | <input type="checkbox"/> Other- <u>must</u> be explained |

*Accounting Use Only

**Hampton Inn/Country Inn/Courtyard Marriott

DESCRIPTION AND/OR EXPLANATION OF PAYMENT:

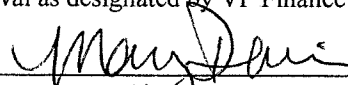
Honorarium for guest speaker for Poe Symposium, The War on Cancer. Offer letter and 204 form, which was previously faxed to Procurement, attached.

ACCOUNTING & APPROVAL:

Account	Fund	Dept ID*	Program	Class	Project/Grant**	Amount
613802	TK910	720	90242			\$1,000.00
Total						\$1,000.00

*Depts. 2xx,3xx,4xx,6xx,9xx require additional approval as designated by VP Finance & Admin.

Requestor: Mary Devins x3253
Printed Name & Extension



Signature

4/23/09

Date

Approver: Dan Wakelee
Printed Name & Extension



Signature

4/23/09
Date

Approver:
(If required) Printed Name & Extension

Signature

Date

April 17, 2009

Dear Dr. Jensen,

Thank you again for your participation in our 5th Annual Poe Symposium, titled "New Weapons For The War On Cancer". This letter is to formalize the invitation and let you know all the details of the event.

The symposium will be held on May 1, 2009 in the lecture hall in Aliso Hall, Room 150, from 12:30 till about 5:45. I have scheduled about 45 minutes for each speaker, which provides time for questions and the inevitable unforeseen incidents. If you would like more or less time, please let me know – there will room for some adjustment.

The schedule of speakers is:

12:30-12:40: Opening remarks by CSUCI President Richard Rush

12:40-12:55: Welcome and introduction to the symposium by Charles Sackerson

1:00-1:50: Calvin Li (Children's Hospital of Orange County): "Tackling pediatric brain tumor stem cells"

1:55-2:45: Glen Begley (Amgen): "The complexity of cancer (or why haven't we cured it yet?)"

2:50-3:40: Lee Rosen (Premiere Oncology): "Ten Plus Years of Inhibiting Angiogenesis: What have we learned? Where are we going?"

3:40-3:55: break

4:00-4:50: Pamela Holland (Amgen): "Pro-apoptotic receptor agonists as a targeted therapy for cancer"

4:55-5:45: Michael Jensen (City of Hope): TBA

We are pleased to offer you an honorarium of \$1,000 in gratitude for your participation, and to cover any travel expenses. Parking on campus will be provided. A lunch will be set up in Aliso Hall, Room 221, and we can meet there if you would like to arrive on campus early. My office is Aliso Hall, Room 101.

Please be in touch if any issues arise.

Sincerely,

Charles Sackerson
Biology Program
California State University Channel Islands
(805) 437-8806
charles.sackerson@csuci.edu

State of California—Department of Health Services

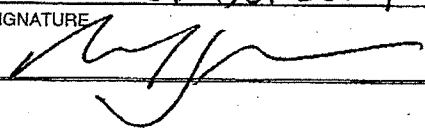
PAYEE DATA RECORD

(Required in lieu of IRS W-9 when doing business with the State of California)

STD 204 (Rev. 2-2000)

Note: Governmental Entities, federal, state, and local (including school districts) are not required to submit this form.

SECTION 1 must be completed by the requesting state agency before forwarding to the payee

1 PLEASE RETURN TO:	DEPARTMENT/OFFICE CSU Channel Islands STREET ADDRESS One University Drive CITY, STATE, ZIP CODE Camarillo, CA 93012 TELEPHONE NUMBER (805) 437-8400	PURPOSE: Information contained in this form will be used by state agencies to prepare Information Returns (Form 1099) and for withholding on payments to nonresident vendors. Prompt return of this fully completed form will prevent delays when processing payments. (See Privacy Statement on Page 2)
2 PAYEE'S BUSINESS NAME Michael Jensen, MD 610 Auburn Avenue MAILING ADDRESS (Number and Street or P.O. Box Number) Sierra Madre, CA 91024 (CITY, STATE, and ZIP CODE)		
3 PAYEE ENTITY INFORMATION	CHECK ONE BOX ONLY <input type="checkbox"/> LEGAL CORPORATION <input type="checkbox"/> MEDICAL CORPORATION <input checked="" type="checkbox"/> EXEMPT CORPORATION (Non-profit) <input type="checkbox"/> ALL OTHER CORPORATIONS FEDERAL EMPLOYER'S IDENTIFICATION NUMBER (FEIN) - <input checked="" type="checkbox"/> INDIVIDUAL SOLE PROPRIETOR SOCIAL SECURITY NUMBER 089-1461-79185 OWNER'S FULL NAME Michael Jensen	NOTE: State and local governmental entities, including school districts are not required to submit this form. NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.
4 PAYEE RESIDENCY STATUS	CHECK APPROPRIATE BOX(ES) <input checked="" type="checkbox"/> California Resident - Qualified to do business in CA or a permanent place of business in CA. <input type="checkbox"/> Nonresident (See Page 2). Payments for services by nonresidents may be subject to state withholding. <input checked="" type="checkbox"/> WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED <input type="checkbox"/> SERVICES PERFORMED OUTSIDE OF CALIFORNIA	NOTE: a. An estate is a resident if decedent was a California resident at time of death. b. A trust is a resident if at least one trustee is a California resident. (See Page 2)
5 CERTIFYING SIGNATURE	I hereby certify under penalty of perjury that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you. AUTHORIZED PAYEE REPRESENTATIVE'S NAME (Type or Print) Michael Jensen, MD TITLE SIGNATURE  DATE 4/21/09 TELEPHONE NUMBER (626) 301-8993	