

Neighborhood Assistance Program Services Contribution Data Sheet

(To be completed and submitted with the CNF-B or CNF-H)

To Be Used For Donated Medical Professional & Mediation Services

(Use Additional Sheet of Paper if Necessary)

NAME OF DONOR:	
ADDRESS:	
TYPE OF SERVICE PROVIDED:	
NAME OF NAP ORGANIZATION:	

JOB TITLE	DATE (List each date separately)	HOURLY RATE (excludes fringes)	TOTAL HOURS WORKED	TOTAL VALUE (Rate x Hours)

NOTE: Other formats providing the same information will be accepted. Sign and attach this form to the CNF or other format and return to the NAP Organization.

CERTIFICATION BY MEDICAL PROFESSIONAL: I certify that the value of the donated service(s) was determined by the standards stated in the instructions and does not exceed the statutory maximum. I also certify I will not receive any type of compensation or reimbursement from insurance filing or from my company for the donated service(s) nor will my company receive any compensation. I understand that if I falsify information, I may be subject to penalties prescribed by the Virginia Departments of Taxation and Social Services.

_____ Date

_____ Signature of Donor