

MENTALLY DISORDERED OFFENDERS ATTORNEY INVOICE

Statement of Services Rendered

HEARING DISPOSITION

Send Invoice to: BOARD OF PAROLE HEARINGS P.O. BOX 4036 SACRAMENTO, CA 95812-4036 Attn: Accounting Liaison Unit	INMATE NAME: _____ CDCR No: _____ LOCATION: _____ SCHEDULED DATE AND TIME OF HEARING: _____ HEARING TYPE: _____
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REIMBURSEMENT RATE	DESCRIPTION OF SERVICES PERFORMED	INITIAL BELOW TO CONFIRM SERVICES PERFORMED
\$40.00	ATTORNEY APPOINTMENT, REVIEW OF BOARD PACKET, DECS AND LEGAL RESEARCH	_____ <i>initials</i>
\$30.00	CENTRAL-FILE REVIEW (Certification Hearings Only)	_____ <i>initials</i>
\$40.00	CLIENT INTERVIEW	_____ <i>initials</i>
\$40.00	PERSONAL APPEARANCE AT THE HEARING	_____ <i>initials</i>

I certify by my initials above that each service was rendered and acknowledge the reimbursement rate represents the maximum compensation which can be received for each type of service. I also certify I am duly licensed to practice before all courts of the State of California and that I am an active member of the State Bar of California.

TOTAL BILLING	
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***Please be sure to submit invoice with an original signature, in *blue* ink.**

ATTORNEY AT LAW (SIGNATURE)*	NAME	S.S. NUMBER#	DATE
ADDRESS NO. & STREET		<input type="checkbox"/> Change of address	CITY
		STATE BAR#	STATE ZIP

DEPARTMENTAL APPROVAL

SIGNATURE	TITLE	DATE
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