MENTALLY DISORDERED OFFENDERS ATTORNEY INVOICE

Statement of Services Rendered

HEARING DISPOSITION

Scan and send invoice via email to the Accounting Liaison Unit at BPHAccountingLiaison@cdcr.ca.gov	INMATE: _____ CDCR No: _____ LOCATION: _____ SCHEDULED DATE AND TIME OF HEARING: _____ HEARING TYPE: _____

REIMBURSEMENT RATE	DESCRIPTION OF SERVICES PERFORMED	INITIAL BELOW TO CONFIRM SERVICES PERFORMED
$40.00	ATTORNEY APPOINTMENT, REVIEW OF BOARD PACKET, DECS AND LEGAL RESEARCH	_____*initials*
$30.00	CENTRAL-FILE REVIEW *(Certification Hearings Only)*	_____*initials*
$40.00	CLIENT INTERVIEW DATE: _____	_____*initials*
$50.00	PERSONAL APPEARANCE AT THE HEARING, APPEAL "POST APPEAL DETERMINATION", ADMINISTRATIVE APPEAL, OR COURT WRITING.	_____*initials*

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	

ATTORNEY AT LAW (SIGNATURE)	NAME	STATE BAR#	DATE

STREET ADDRESS	❑ *Change of address*	CITY	STATE	ZIP

DEPARTMENTAL APPROVAL

SIGNATURE	TITLE	DATE