OFFENDERS WITH A MENTAL HEALTH DISORDER ATTORNEY INVOICE

Statement of Services Rendered

HEARING DISPOSITION

Send Invoice to:	INMATE NAME:_____
BOARD OF PAROLE HEARINGS P.O. BOX 4036 SACRAMENTO, CA 95812-4036 Attn: Accounting Liaison Unit	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	_____*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	

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

ATTORNEY AT LAW (SIGNATURE)*	NAME	S.S. NUMBER# STATE BAR#	DATE

ADDRESS NO. & STREET	❑ *Change of address*	CITY	STATE	ZIP

DEPARTMENTAL APPROVAL

SIGNATURE TITLE DATE