

SAN BERNARDINO COUNTY SUPERIOR COURT

PC 1026, EC 1017

EVALUATION SERVICES CLAIM

Use Court Form No. 12-21283-356 for:
 PC1368 Competency, PC288 Sex Offender and
 W&I 3051 Addiction Evaluation Services

INTERNAL USE ONLY			
COUNTY ISSUED VENDOR CODE	GENERAL LEDGER	INVOICE NUMBER	DOCUMENT TOTAL
	5 2 0 0 2 4 4 5		\$

Invoice Date _____ Page ___ of ___

(PLEASE TYPE OR PRINT LEGIBLY) <input type="checkbox"/> CHECK HERE IF NEW ADDRESS CLAIM OF _____ ADDRESS _____ CITY, STATE _____ ZIP _____ E-MAIL _____ PHONE _____	MUST ATTACH COPY OF LETTER OF APPOINTMENT OR FILE-STAMPED ORDER IN SUPPORT OF SERVICES BILLED	TYPE OF EVALUATION	FEE
		PC 1026 Not Guilty by Reason of Insanity evaluation and report \$650 EC 1017 Defense-requested confidential evaluation and report \$650 Adelanto Detention Center stipend \$50 Court testimony — half day (Must attach copy of subpoena/court order) \$350 Court testimony — full day(Must attach copy of subpoena/court order) \$600 Payment is the responsibility of the subpoenaing party (LRC 1460.9). Unable to perform exam after 2 attempts/Hearing postponed with insufficient notice. \$325 Extensive medical record review > 100 pages. \$60/hour (60 pages/hour) Max \$300 Mileage Current Court-Approved Rate	

VERIFYING OFFICIAL If defendant is represented by the Public Defender, forward approved claim to: 0008: Public Defender's Office, Attn: Accounts Payable
 If defendant is represented by a private attorney, forward approved claim to 0123: County Administrative Office, Attn: Indigent Defense Analyst

CASE NUMBER	TYPE OF EVALUATION (see above)	DATE OF EVALUATION	DEFENDANT AND LOCATION*	COURT TESTIMONY ONLY			FEE	MILES DRIVEN **	TOTAL FEE
				JUDGE/ DEPARTMENT	DATE OF TESTIMONY	TIME AM PM			
USE THIS CLAIM FORM FOR PC 1026 AND EC 1017 SERVICES ONLY									

*Indicate where evaluation occurred adjacent to defendant name: West Valley DC; Central DC; Adelanto DC; Patton SH; or other (specify)

**Expert's Physical Address (if mileage claimed):

Additional claim forms and the Court's Local Rules and Appointed Services Fee Schedule are available on the Court's website: www.sb-court.org

CLAIM TOTAL \$

EC 1017 EXAM ONLY I hereby certify that I have reviewed this billing and that these services were performed at my request. The charges shown are recommended for payment as reasonable and appropriate. _____ Signature of Attorney Date	I hereby certify under penalty of perjury that the foregoing claim for service is true and correct (CCP 2015.5), that I have been continually licensed in the State of California as a psychologist/ psychiatrist for the time period during which the services claimed above were rendered, and that no part of this claim has previously been presented or paid. _____ Signature of Claimant Date and Place	I certify that the above services were directed by the appropriate authority and verified in accordance with established procedures. _____ Approving Authority Date
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COUNTY REVIEWER PAYMENT APPROVAL: I hereby certify that I have examined the facts of the transaction herein set forth as evidenced by the information hereon and the documents attached hereto. All verifications, certification, and checking of computations required by the County Charter and Government Codes have been complied with and this claim in the total amount shown is hereby approved for payment.