



**SUPERIOR COURT OF CALIFORNIA, COUNTY OF SANTA CLARA
COURT APPOINTMENT FORENSIC EVALUATION
COMPENSATION CLAIM FORM AND SUPPORTING AFFIDAVIT**

Doctor's Name: _____ Date of Appointment: _____

Defendant/Minor Full Name: _____ Case Number: _____

Type of Proceeding: Adult PC1368/1369 Adult PC1026/1027 Adult W&I 6605
 Adult EC1017* Adult PC 288.1 Juvenile Competency Report
 Juvenile WIC 702.3 (d) Juvenile EC1017* Other: _____

*EC 1017 Report: Date report submitted to Defense Counsel: _____

Evaluation Interview

Date of Interview: _____ Duration of Interview: _____ Pages Reviewed: _____

Preparation for Interview:

Testing

Amount of Testing: No Testing 1 hour 2 hours

Types of Test(s) Administered:

Fee Calculation

Basic Evaluation and Report Fee (first two hours) \$750 or EC 1017 \$500: \$ _____

\$ _____

Review/Testing (two hours maximum) @ \$125/hour: \$ _____

Pre-approved additional funding (*Attach approved request form* \$ _____

CR-6080)(If Request for additional funds not attached it will delay payment)

Testimony time Dept. #

Testimony date(s): _____ @ \$250/ half-day and/or \$425/ full day \$ _____

Other: _____ \$ _____

Total Compensation Requested: \$ _____

I hereby declare under penalty of perjury that to the best of my knowledge the foregoing information is true and accurate in every respect.

Date

Evaluator's Signature

Mailing Address:

Phone#:

FOR COURT USE ONLY

I acknowledge receipt of the report or appointment under EC 1017 and the services are rendered as requested.

Approved by: _____ Dated: _____
Director/or their designee