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) $350: $_____

Testing (two hours maximum) @ $95/hr MD or $85/hr PhD: $_____

Pre-approved additional funding (*Attach approved request form CR-6080)* $_____

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

Testimony time in Dept. # _____

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

Other: _____ $_____

Total Compensation Requested: **$** 0.00

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#: _____

Reset Form **Print**

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: _____

Asst. Director/Juvenile Supervisor