

Master Agreement Number: _____	
Independent Contractor	Worksite Name: _____
Psychiatrist Name: _____	Worksite Address: _____
Month and Year: _____	_____
Date Submitted: _____	Invoice Number: _____

Date Worked	Hours	Hourly Rate	Description	Amount
		\$		\$
Monthly Invoice Total				\$

I hereby certify that the above information is true and correct and that the psychiatry services and administrative costs reflected above are eligible for reimbursement under the terms and conditions of the As-Needed Psychiatry Services Master Agreement between the County and Contractor.

Contractor Authorized Person (Print Name)	Signature	Date
<p>I confirm that the time reported above has been verified and approved.</p>		
Initial Reviewer (Print Name)	Signature	Date
L.A. County Authorized Person (Print Name)	Signature	Date