COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH AS-NEEDED PSYCHIATRY SERVICES INVOICE

FROM:			то:	
Contractor Name:			County of Los Angeles - Department of Mental Health	
Contractor Address:			Attention: Office of the Chief Medical Officer - CMO Administration	
Contractor City, State, Zip:			510 S. Vermont Avenue, 22nd Floor	
Contractor Phone:			Los Angeles, CA 90020	
Contact Person:				
Contact Email Address:				
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 inf the terms and conditions of the A			rvices and administrative costs reflected above an ween the County and Contractor.	e eligible for reimbursement under
Contractor Authorized Person (Print Name)			Signature	Date
I confirm that the time reported a	bove has been verifie	ed and approved.		
Initial Reviewer (Print Name)			Signature	Date
L.A. County Authorized Person (Print Name)			Signature	 Date