

COUNTY ASSIGNED COUNSEL PROGRAM

Voucher & Invoice for Legal Services

Attorney Name:

Date:

Address:

Voucher #:

Tax ID/SSN:

Phone:

CASE INFORMATION

Defendant/Client:

Case #:

Court:

Charge/Matter:

Disposition:

Date Closed:

Date	Description of Service (In-Court / Out-of-Court)	Hours	Rate	Total

Date	Description of Service (In-Court / Out-of-Court)	Hours	Rate	Total

REIMBURSABLE EXPENSES (Travel, Photocopies, etc.)

Date	Expense Description	Amount

TOTAL CLAIM AMOUNT: \$ _____

Attorney Signature

Presiding Judge / Administrator Approval