Professional Services Authorization Form

CLARK COUNTY
WASHINGTON
PUBLIC DEFENSE

Service Type (select one): Service Type

Attorney Name: _____
Defendant's Name: _____
Cause Number(s): _____
Charge(s): _____
Custody Status: _____
Next Court Date: _____

Supplier Name: _____
Supplier Phone: _____
Address & Email (*if new supplier*): _____

Amount Requested: _____
Rate (if applicable): _____ per hour
_____ per mile

List Prior Authorization(s)

Date	Amount

Per CrR 3.1(f), CrRLJ 3.1(f) or JuCR 9.3(a) the services requested are necessary for an adequate defense.

Date:

Attorney for Defendant:

CCPD USE ONLY	
Amount Approved:	
By:	
Date:	

Professional Services Authorization Form

Request Notes:

SEND FORM TO CNTY.PUBLICDEFENSE@CLARK.WA.GOV FOR REVIEW

FILL OUT FORM COMPLETELY OR IT WILL BE RETURNED

REQUESTS MUST INCLUDE THE FOLLOWING INFORMATION

1) Provider's Name
2) Request Date
3) Client Name & Cause Number
4) Rate of service (if applicable)
5) Total Amount Requested
6) Today's Date and Signature of Attorney

Provider invoices must bill to “Clark County Public Defense” and not the attorney. For example, if an attorney requests medical records from Peace Health SW Medical Center, be sure to include in the records request that the hospital’s invoice must be sent to:

Clark County Public Defense
PO Box 5000
Vancouver, WA 98666-5000

CNTY.PUBLICDEFENSE@CLARK.WA.GOV

PLEASE SUBMIT INVOICE WITHIN 30 DAYS OF SERVICES RENDERED

Thank you for your assistance!

FILL OUT FORM COMPLETELY OR IT WILL BE RETURNED