**“Interview/Deposition” Billing Form**

**(ORS 656.262(14)(a); OAR 438-015-0033)**

To:

 (Insurer, Self-Insured Employer, Claim Administrator)

Claimant:

 (*Attach a copy of the Executed*

Claim No: *Retainer Agreement, unless*

 *previously provided.)*

Date of Injury:

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Interview/****Deposition** | **Actual Time Spent****During Interview/****Deposition** | **Reasonable Hourly****Rate** | **Total** |
|  |  | @ $418 hr. | $ |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

 I hereby confirm that the above time was actually spent by me during a personal or telephonic interview or deposition conducted under ORS 656.262(14)(a).

 (Claimant’s Attorney Signature) (Date)

 (Printed Name of Claimant’s Attorney)

 (Address)

(Phone)

*Billing form must be submitted to carrier within 30 days of completion of the interview or deposition. OAR 438-015-0033(3).*

*Unless a hearing request is filed within 30 days of the carrier’s receipt of this bill, payment must be made within that 30-day period. OAR 438-015-0033(5).*