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Rule 12.36—Form 14b: ***Claim for Physician Fees***

In the Iowa District Court for _____ **County**
County where Claim is filed

In the Matter of _____, **Respondent** *Full name: first, middle, last* **Alleged to be Seriously Mentally Impaired**	No._____ **Claim for Physician Fees** Iowa Code § 229.10

1. I, the undersigned physician, state that pursuant to Iowa Code section 229.10, I examined Respondent, alleged to be seriously mentally impaired, and that services have been completed as set forth in the itemized statement provided with this Claim and that I have not directly or indirectly received or entered into a contract to receive any compensation for such services from any sources.

2. I request an order to be compensated in accordance with the provisions of Iowa Code section 229.10.

3. Oath and signature

I, _____, have read this Claim, and certify under
Print your full name: first, middle, last

penalty of perjury and pursuant to the laws of the State of Iowa that the information provided in this Claim is true and correct.

_____ _____, 20___ _____
Month *Day* *Year* *Claimant's signature**

_____
Name of hospital or facility

_____
Mailing address

_____, _____ _____
City *State* *ZIP code*

(____) _____
Phone number

_____ _____
Email address *Additional email address, if applicable*

**This form may be signed either by using a digitized signature, see instructions at https://www.iowacourts.gov/for-the-public/court-forms/, or by printing and hand-signing.*