Forensic Medical Examination Fund
INVOICE

Date:

TO: (Prosecuting Attorney's Name and Office Address)

REMIT PAYMENT TO: (Hospital's Name and Billing Address)

Forensic Medical Examination		
Name of Victim	Date of Alleged Offense	Fee
		$
Pediatric Exam _____ Adult Exam _____	Hospital Invoice #	

Attached statement of itemized charges

Certification/ Authorization:

I, ____, Prosecuting Attorney, or Law Enforcement Officer of ______________________ County, West Virginia, do hereby certify that the charges listed above were for the purpose of performing a forensic medical examination pursuant to an investigation of an alleged sexual assault in accordance with West Virginia Code section 61-8B-1.

____ ____________________
Prosecuting Attorney/ Law Enforcement Officer County/ Detachment

Please attach this form and the original hospital invoice and forward to:

WV Prosecuting Attorneys Institute
Attn: FMEF
90 MacCorkle Ave, SW, Ste 202
South Charleston, WV 25303