GEORGIA DEPARTMENT OF HUMAN RESOURCES

SALARIED SEC.1 | **STATE AGENCY IMPORTANT** | **BILL FOR SERVICES RENDERED (DHR)**

Approving authority should complete only checked (√) items in this section – Travel Unit to complete remainder of this section.

TC 102	REFERENCE NO.	ORDER NO.	EFFECTIVE DATE	TYPE 10	PAY DATE	INVOICE **	LOCATOR CODE	PAYEE'S LAST NAME
OVERRIDE	PCOA	LIAB.SCOA 211.100	ORGANIZATION NO.	CLASS 2	PROJECT	FUND SOURCE	VENDOR CODE	

ITEM CODE	DESCRIPTION	SCOA	AMOUNT	PROCESSED BY/DATE
	DESCRIPTION OF SERVICE (From Section IV)			
	TRAVEL REIMBURSEMENT (Total Reimbursement Claimed in Section V)	651.40		ENTERED BY/ DATE
		TOTAL		

INDICATE ONE OF THE FOLLOWING (CHECK √ ONE)

☐ MINORITY ☐ SMALL ☐ BOTH MINORITY AND SMALL ☐ NEITHER MINORITY OR SMALL

MINORITY – A member of a minority race is defined as an individual who is a member of a race which comprises less than 50 percent of the total population of the State of Georgia. A minority-owned business can be one of the following: (1) a business which is owned by a member of a minority race or (2) a partnership of which a majority interest is owned by one or more members of a minority race or (3) a public corporation of which a majority of the common stock is owned by one or more members of a minority race.

SMALL A small business concern is an independently owned and operated enterprise with either less than 100 employees or less than $1,000,000 in gross receipts per year.

Give appropriate SCOA from list below:

TITLE	SCOA
Attorney	651.10
Veterinarian	651.80
Board Member	651.50
Physician	651.60
Consultant	651.20
Other Fees	651.100

It is departmental policy that Architects and Engineers must be paid by contractual arrangements only.

SEC II: PAYMENT		Professional Title	Degree Held	USE 1 BLOCK ONLY
Make Check Payable To (Type or Print full name of person or company)		Date	CHECK ONE ☐ Individual or Sole Proprietor	Social Security Number (Individual or Sole Proprietor)
Address (Street)			☐ Incorporated, provide Medical Scvs. ☐ Incorporated, Other Services	FEI Number (ALL OTHERS)
(City)	(State)	Zip Code	☐ Company, Not Incorporated ☐ Non-Profit Org. or Government	Area Code and Telephone

SEC III ***REVERSE SIDE MUST BE COMPLETED BEFORE THIS STATEMENT WILL BE PROCESSED FOR PAYMENT***

APPROVAL/AUTHORIZATION (For Use Only By Department of Human Resources)

NOTE: Payment for services cannot be made unless a previously approved Form 5317 (Request for Fee-Paid Service) is attached to this form; or the approved unclassified position number (from Form 5331 – Request to Establish an Exempt Position) is provided in the appropriate block.

I hereby certify the validity of this statement of my services, hours, and expenses and that I am not a salaried employee of any State Agency, Institution, Department, Commission, or Authority to include the University System.	CONSULTANT (Signature)
I hereby certify the validity of this statement of my services, hours, and expenses and that I am a salaried employee of _______________ from which appropriate certification for my services has been obtained. I understand that any duplication of these claims for services or expenses to be paid by another State Agency is a violation of the law and I will be held liable.	CONSULTANT (Signature)
This person is a salaried employee of another State Agency. The necessary certifications for part-time employment with the Department has been obtained. The Department Certification number is ________________________________. *I hereby approve the foregoing request and authorize payment.*	APPROVED (Signature)
I certify that the individual claiming reimbursement is not employed by any State Agency, Institution, Department, Commission, or Authority and I approve the foregoing request and authorize payment.	APPROVED (Signature)

PAYMENT RATE $_____ Per (hour)(day)	TOTAL REMUNERATION $	UNCLASSIFIED POSITION NO.	Name (Type or Print)	Bus. Phone / GIST Phone	Date
			Title	Unit	

In those cases of interagency cooperation where the employee of one department has travel expense reimbursed by another department, certification of part-time employment is not required.

GEORGIA DEPARTMENT OF HUMAN RESOURCES
BILL FOR SERVICES RENDERED (DHR)

In accordance with appropriate authorization, I have served as a part-time professional consultant to the Georgia Department of Human Resources for the time shown below.

MONTHLY RETAINER
(If Applicable)

$

SEC. IV SERVICES/HOURS

DATE(S) OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SERVICE/PURPOSE OF TRAVEL	NUMBER OF HOURS
		TOTAL	

EXPLAIN ANY EXPENSES THAT ARE UNUSUAL OR EXCEED ESTABLISHED LIMITS:
EXPLAIN TELEPHONE & TELEGRAPH CHARGES:

SEC. V EXPENSES

DATE	A. TRANSPORTATION (Complete only those items for which you are claiming reimbursement)								B. MEALS & LODGING (Entries should not exceed approved maximum rates and must include city where meals are taken.)					C.TELE PHONE & TELE-GRAPH	D. REGIS-TRA-TION
Mo/Day	Time *Departure Return*	Origin – Points Visited Destination	State Use Miles *Personal Vehicle*	Odometer Reading *Beginning Ending*	Amount Common Carrier *Attach Receipt*	Parking & Tolls *Attach Receipt*	Taxi or Limou-sine	Porterage(s)	Breakfast *Amount Location*	Lunch *Amount Location*	Dinner *Amount Location*	Total Meals	Lodging *Attach Receipt*	*Explain Above*	*Attach Receipt*
		Sub-Totals	*____ Miles @ ____ c* $		$	$	$	$				$	$		
		TOTALS	**A. TRANSPORTATION $**						**B. MEALS & LODGING $**			$	$		
			TOTAL REIMBURSEMENT CLAIMED (A+B+C+D)											$	