REQUEST FOR PAYMENT
FOR QUALIFIED INTERPRETER

STATE OF SOUTH CAROLINA	)	IN THE COURT OF
	)	_____
COUNTY OF	)	
	)	_____ JUDICIAL CIRCUIT
_____	)	No.
Plaintiff	)	
	)	CASE NO. _____
vs.	)	
	)	
_____	)	
Defendant	)	

Pursuant to S.C. CODE ANN. Sections 15-27-15, 15-27-155, or 17-1-50, claim is hereby made for compensation of the services of a qualified interpreter who has been approved by the Court. Note: Interpreters will receive an hourly rate for services rendered in **one day (not per case), with a two-hour minimum**. If interpreting services exceed one day, the hourly rate per hour will be paid for actual time of services rendered (to the nearest quarter-hour).

_____ Hours at $_____ per hour $_____

_____ Miles from _____ City / _____ County To _____ City / _____ County at $0.58 = $_____

TOTAL $ _____

Mileage may be reimbursed at the official state rate when assignment is outside residence county or place of business.

I hereby certify that this is a true and correct statement of my mileage and services rendered for interpreting the court proceeding to a deaf or non-English speaking person who is a juror or a party to the proceeding or a witness therein.

_____ _____

Signature of Interpreter | Printed Name of Interpreter

I am (check one): ☐ S.C. State Employee ☐ Privately Employed

(State employees attest by their signature that they did not perform these services as part of their normal duties or on State time.)

CHECK WILL BE MADE PAYABLE AND MAILED TOTHE INDIVIDUAL OR FIRM LISTED BELOW.

SOCIAL SECURITY OR F.E.I. NUMBER MUST BE INCLUDED. IF A W-9 IS NOT ON FILE, PLEASE ENCLOSE.

NAME: _____

ADDRESS: _____

_____

TELEPHONE NO.

_____

Last Four Digits of S. S. # (ONLY) or F. E. I. #:

_____

APPROVED BY: Presiding Judge

X _____

_____

Printed Name of Judge

Date: _____

SCAA/263 (1/2019) NOTE: Original form or Certified True Copy only. Forms not in compliance will be returned.