LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
OFFICE OF ADMINISTRATIVE OPERATIONS

Mental Health Psychiatrist Recruitment Incentive

CLAIM FORM

Upon completion of one continuous year of service, please complete this form and submit to Office of Administrative Operations at MDIncentive@dmh.lacounty.gov

INCOMPLETE OR ILLEGIBLE CLAIM FORM WILL BE REJECTED

I request the Recruitment Incentive award payment of $__________________

☐ Year 1 ☐ Year 2

FULL NAME:	**SSN:**

PROGRAM:	**JOB TITLE:**	**EMPLOYEE NUMBER:**

AGENCY/PROGRAM ADDRESS:

HOME ADDRESS:

CITY:	**STATE:**	**ZIP:**

PHONE #:	**Business E-MAIL:**

Service Obligation Date: ______ From ______ To	**Comments:**

The following requirement documents are attached:

- ☐ Copy of current Driver's License to validate identification
- ☐ Current DMH Employment Performance Evaluation

Awardee's Signature ______________________ Date ______________

TO BE COMPLETED BY OFFICE OF ADMINISTRATIVE OPERATIONS ______________________

This claim is: ☐ Approved ☐ Denied

Signature of Authorized Staff ______________ Print Name ______________ Date ______________