



Rancho Los Amigos National Rehabilitation Center

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT: CONFLICT OF INTEREST

Policy No.: A229
Supersedes: June 9, 2006
Revision Date: September 3, 2013
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PURPOSE:

b govern activities which, may be in conflict with and adversely affect job duties and responsibilities

PROCEDURE:

The essential nature of services rendered by the Department, the fact that many County patients are not agents of free choice, the trust involved in the expenditures of large sums of tax money and the obligation to maintain public confidence in government all require that employees of the Department at every level remain sensitive to potential conflict of interest situations and be alert to avoid them. Employees of the Department of Health Services shall avoid referral of County patients or clients for private reimbursable services to themselves or to any group with which they are associated. In cases where suitable and alternative services are not available, where administrative regulations permit and the best interests of the patient indicate, a County employee may accept the patient or client for private purposes after providing documentation of the justifying circumstances..

The law places the burden of responsibility upon the employee to disclose and report all potential conflict of interest situations, document the circumstances and secure from the head of the division, appropriately concerned consultation and approval of the procedure to be followed which will be designed to protect the Department, the employee, and the public. The law also precludes employees with conflicts of interest from participating in any County decisions regarding the contractor or its contracts with the County

In the event a potential conflict of interest situation is reported, an investigation will be conducted by the Director of Human Resources and appropriate action taken.

REFERENCE: Department of Health Services, Policy No. 740

AC:gg

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
Conflict of Interest Disclosure Form

EMPLOYEE TO COMPLETE UPPER PORTION OF FORM AND SUBMIT TO IMMEDIATE SUPERVISOR

If Not Applicable (N/A), check box and skip to employee signature and date.

Employee Name:		Employee #:	
Facility/Program:		Dept. #:	
Address:			
	(Street)	(City)	(Zip Code)
Work Phone #:		Employee's Payroll Title:	
Immediate Supervisor:		Supervisor's Phone:	

Use Lines below to describe the conflict of interest situation:

Note: If the conflict of interest situation involves non-county employment, you must obtain prior approval using the Outside Employment Reporting Form and approval process. Your signature below certifies that the above information is true and complete. Failure to disclose all conflict of interest information accurately will subject you to disciplinary action, including discharge from County service.

Employee Signature:	X	Date:	
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I have reviewed the information above and discussed it with the employee. We have agreed to resolve the situation in the following way in order to best protect the interest of the County:

Immediate Supervisor's Signature:		Date:	
Division Head Approval:		Date:	