LOS ANGELES COUNTY **LAC+USC MEDICAL CENTER**

AGREEMENT OF UNDERSTANDING

Please PRINT NAME (Last, First):	**Employee Number:**	**Work Area/Shift:**
Job Class:	**Item #:**	**Dept. Pay Location:**

I acknowledge that I have read and reviewed the following L.A. County policies and will comply with them in my work environment:

POLICY/ FORM	TITLE	Employee's Initials	Supervisor's Initials
DHS 392.3	Hand Hygiene in Healthcare Settings—The Joint Commission Requirements		
DHS 749	Sexual Harassment Policy		
DHS 792	Threat Management "Zero Tolerance" Policy		
DHS 911	Role of DHS' Employees in the Event of an Emergency		
DHS 935.20	Acceptable Use Policy for County Information Technology Resources		
DHS 940	Identification Badges Policy		
DHS 740	Outside Employment/Incompatible Activity, Conflict of Interest and State of California Conflict of Interest and Disclosure Code, and Dual Compensation Policy **Employees Receiving Dual Compensation:** All employees engaged in employment with affiliating Medical School, Staff Association and/or physicians implementing research grants are required to complete the Employee's Report of Dual Compensation and Employee Certification forms. **Check one:** ❑ **NONE:** I do not engage/intend to engage in employment with affiliating Medical School, Staff Association, and/or physicians implementing research grants. ❑ **YES:** I am engaged/intend to engage in employment with _____ School of Medicine, its professional staff association, and/or an affiliated physician conducting research under grant funding, reporting directly to _____ _____. Such employment began/will begin on _____. Following is additional information regarding my proposed employment for this entity. **FORMS ATTACHED.** **Employee Conflict of Interest:** Employees involved in the making or participating in the making of decisions which may foreseeable have a material effect on the employee's private financial interests must disclose the situation per Conflict of Interest and Disclosure Code. Employees must disqualify themselves from participating in, influencing or attempting to influence a County decision in which they have a financial interest. **Check one:** ❑ **NONE:** I do not have a conflict of interest situation. ❑ **YES:** I have a conflict of interest situation to report. **FORM ATTACHED.** **Employee's Report of Outside Employment/Incompatible Activity:** All employees with outside employment are required to complete annually or upon commencement of employment the Employee's Report of Outside Employment/Incompatibility Activity forms. **Check one:** ❑ **NONE:** I do not engage/intend to engage in outside employment. ❑ **YES:** I do engage/intend to engage in outside employment. **FORMS ATTACHED.**		
	■Performance Evaluation Attachment – Review and Verification of Required Information		
	■Notice of Child Abuse Reporting, Elder/Dependant Adult Abuse Reporting		
	■County of Los Angeles – Department of Health Services Policy on Time Reporting		
	■Orientation to Basic Fire Procedures		
	■Orientation to Disaster Plan		
	■ Confidentiality of Records		

I am aware that if I violate the above policies, I will be subject to disciplinary action up to and including warning, reprimand, suspension and/or discharge from County employment.

_____ _____/_____ _____

Employee's Signature **Initials** **Date**

_____/_____ _____

Supervisor's Signature **Initials** **Date**

Distribution: Original - Official Employee Personnel Folder in OHR, Duplicates – (1) Department Area File, (1) Employee

CHOICE OF PHYSICIAN FOR INDUSTRIAL INJURY/ILLNESS – EMPLOYEE OPTION

State law allows employees to be treated by their personal physician immediately after injury/illness providing the employee has previously submitted written notice to his/her employer of this choice. Employees who wish to be treated by their own physician in case of industrial injury/illness must complete the Statement on Workers' Compensation law regarding Choice of Physician. Unless an employee has provided this information, all medical referrals for industrial injury/illness will be made from the County Medical Directory.

(Additional forms are available in the Personnel Office.)

DECLARATION OF CHOICE OF PHYSICIAN IN CASE OF INDUSTRIAL INJURY/ILLNESS (PLEASE PRINT)		
EMPLOYEE'S NAME	EMPLOYEE #	DEPARTMENT PHONE # ( )
PERSONAL PHYSICIAN/MEDICAL GROUP'S NAME		PHYSICIAN/MEDICAL GROUP' S PHONE# ( )
STREET ADDRESS/CITY/ZIP CODE (Personal Physician/Medical Group)		
I wish to be treated by my personal physician in case of industrial injury/illness. My personal physician meets the requirements of SENATE BILL 520, which states that he/she must have previously provided medical care for me, and retains my medical records. I understand that my personal physician must file prompt, and complete medical reports with the Los Angeles County Worker's Compensation Claims Section, and will adhere to the Worker's Compensation Fee Schedule. I have also read the above statement regarding the new Worker's Compensation Law.		
_____ EMPLOYEE'S SIGNATURE		_____ DATE

CURRENT HOME ADDRESS/TELEPHONE NUMBER

It is the employee's responsibility to keep his/her personnel office and supervisor informed of their current home address and phone number. Please provide the following:

HOME ADDRESS AND TELEPHONE			
ADDRESS:	Number	Street	**TELEPHONE NO.**
City		State	Zip Code

EMERGENCY CONTACT INFORMATION

Please complete the following information about someone who can be contacted in an emergency involving you.

Person To Notify (Full Name)	**Relationship**
Telephone No. (Home)	**Telephone No. (Business/Cell)**
Person To Notify (Full Name)	**Relationship**
Telephone No. (Home)	**Telephone No. (Business/Cell)**

VERIFICATION OF LICENSE CERTIFICATE OR REGISTRATION

Any employee whose position requires a valid license/certification/registration to perform the duties of his/her position is responsible for ensuring that the license/certificate/registration is kept current. Failure by an employee to maintain the required license/certificate/registration may result in demotion or discharge from County service. The employee must provide the original documentation for verification. If there is a change in status of license certificate or registration employee shall notify supervisor. If required complete the following:

Type of License/Certificate	License/Certificate Number	Expiration Date	Supervisor's Verification	Date Verified

VERIFICATION OF ANNUAL HEALTH EVALUATION

In order to be in compliance with the California Health and Safety Code, an annual physical evaluation is required of all employees in the LAC+USC Medical Center. You must certify that the employee has had his/her annual evaluation.

VERIFIED BY: _____ **DATE VERIFIED:** _____

I hereby acknowledge that I have read and fully understand all of the above required information.

EMPLOYEE'S SIGNATURE	EMPLOYEE NUMBER	DATE
SUPERVISOR'S SIGNATURE		DATE