FIRST AMENDMENT 2010-11

TO AGREEMENT FOR SERVICES OF CONTRACTOR ON PAYROLL

This is an amendment (hereafter referred to as the “First Amended Contract”) to the Agreement for Services of a Contractor on Payroll, **BC 05-012**, by and between the **County of Santa Barbara** (County) and **Bob Black, MD** (Contractor), for the continued provision of **Psychiatric Services**.

Whereas, this First Amended Contract incorporates the terms and conditions set forth in the contract approved by the County Board of Supervisors in June 2010, except as modified by this First Amended Contract.

Whereas, County anticipates that Contractor will provide a lower number of services than contemplated by the original Agreement. This amendment decreases the amount of funds in the Agreement accordingly.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, County and Contractor agree as follows:

I. Delete Exhibit B, Contractor on Payroll Compensation, and replace with the following:

EXHIBIT B

CONTRACTOR ON PAYROLL
Compensation

COUNTY shall pay **CONTRACTOR** for professional services pursuant to this Agreement upon biweekly submission by **CONTRACTOR** of a timesheet, and such payment shall be subject to deductions and withholding of state and federal taxes. In no event shall the compensation payable exceed the total sum of $68640 without written amendment. This not to exceed amount includes the following:

- $68640 for 624 hours of work by **CONTRACTOR** at a rate of $110.00 per hour.

FIRST AMENDMENT 2010-11

Agreement for Services of Contractor on Payroll between the **County of Santa Barbara** and Bob G. Black, MD.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on 3/15/11.

COUNTY OF SANTA BARBARA

By: ______________________________
JONI GRAY
CHAIR, BOARD OF SUPERVISORS

Date: ____________________

ATTEST:
CHANDRA L. WALLAR
CLERK OF THE BOARD

By: ______________________________
Deputy

APPROVED AS TO FORM:
CEO/HUMAN RESOURCES

By: ________________________
Human Resources Director

Date: ______________________

CONTRACTOR

By: ______________________________
SocSec or TaxID Number:

Date: ______________________

APPROVED AS TO FORM:
DENNIS MARSHALL
COUNTY COUNSEL

By: ______________________________
Deputy County Counsel

Date: ____________________________

APPROVED AS TO ACCOUNTING FORM:
ROBERT W GEIS, CPA
AUDITOR-CONTROLLER

By: ______________________________
Deputy

Date: ____________________________

APPROVED AS TO FORM AND CONTENT:
ANN DETRICK, PHD

By: ______________________________
Department Director

Date: ______________________________

APPROVED AS TO FORM:
RISK MANAGEMENT

By: ______________________________
Risk Management

Date: ______________________________

FIRST AMENDMENT 2010-11

Contract Summary **BC 05-012**

D1. Fiscal Year: FY 10-11
D2. Budget Unit Number: 043 (043-02-01-2110-0)
D3. Requisition Number: N/A
D4. Department Name: Alcohol, Drug and Mental Health Services
D5. Contact Person: Erin Jeffery
D6. Phone: (805) 681-5168
K1. Contract Type *(check one)*: [**X**] Personal Service [ ] Capital Project/Construction
K2. Brief Summary of Contract Description/Purpose: Psychiatric Services
K3. Original Contract Amount: $86900
K4. Contract Begin Date: 7/1/2010
K5. Original Contract End Date: 6/30/2011
K6. Amendment History *(leave blank if no prior amendments)*:

Seq#	*EffectiveDate*	*ThisAmndtAmt*	*CumAmndtToDate*	*NewTotalAmt*	*NewEndDate*	*Purpose(2-4 words)*
1	3/15/11	$-18260	$-18260	$68640	6/30/11	Reduce hours

K7. Department Project Number:
B1. Is this a Board Contract? *(Yes/No)*: Yes
B2. Number of Workers Displaced *(if any)*: N/A
B3. Number of Competitive Bids *(if any)*: N/A
B4. Lowest Bid Amount *(if bid)*: $
B5. If Board waived bids, show Agenda Date:
B6. … and Agenda Item Number: #
B7. Boilerplate Contract Text Unaffected? (Yes / or cite ¶¶): Yes
F1. Encumbrance Transaction Code: 1701
F2. Current Year Encumbrance Amount: $68640
F3. Fund Number: 0044
F4. Department Number: 043
F5. Division Number *(if applicable)*: N/A
F6. Account Number: 6177
F7. Cost Center number *(if applicable)*:
F8. Payment Terms: Net 30
V1. Vendor Numbers *(A=uditor; P=urchasing)*: BC 05-012
V2. Payee/**CONTRACTOR** Name: Bob G. Black, MD
V3. Mailing Address: 1136 Arbolado Road
V4. City State *(two-letter)* Zip *(include +4 if known)*: Santa Barbara, CA 93103
V5. Telephone Number: 8059662797
V6. **CONTRACTOR'S** Federal Tax ID Number *(EIN or SSN)*:
V7. Contact Person: Bob Black, MD
V8. Workers Comp Insurance Expiration Date: N/A
V9. Liability Insurance Expiration Date[s] *(G=enl; P=rofl)*: N/A
V10. Professional License Number: #C 42375
V11. Verified by *(name of County staff)*: Erin Jeffery
V12. Company Type *(Check one)*: [**X**] Individual [ ] Sole Proprietorship [ ] Partnership [ ] Corporation

I certify the following: information is complete and accurate; designated funds are available; required concurrences are as evidenced on signature page.

Date: __________________ Authorized Signature: ____