

FIRST AMENDMENT 2009-2010

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, number **BC 05-131**, by and between the **County of Santa Barbara** (County) and **Kellee Clougherty, MD** (Contractor), for the continued provision of **Children's Psychiatrist Santa Barbara**.

Whereas, this First Amended Contract incorporates the terms and conditions set forth in the contract approved by the County Board of Supervisors in June 2009, except as modified by this First Amended Contract.

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 \$126840 without written amendment. This not to exceed amount includes the following:

- \$116,880 for 974 hours of work by **CONTRACTOR** at a rate of \$120.00 per hour.
- \$9,960 for 83 hours of paid leave paid via payroll.

FIRST AMENDMENT 2009-2010

Agreement for Services of Contractor on Payroll between the **County of Santa Barbara** and Kellee Clougherty, MD.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on 12/8/09.

COUNTY OF SANTA BARBARA

ATTEST:
MICHAEL F. BROWN
CLERK OF THE BOARD

By: _____
Chair, Board of Supervisors

Date: _____

By: _____
Deputy

APPROVED AS TO FORM:
CEO/HUMAN RESOURCES

CONTRACTOR

By: _____
Human Resources Director

By: _____
SocSec or TaxID Number:

Date: _____

Date: _____

APPROVED AS TO FORM:
DENNIS MARSHALL
COUNTY COUNSEL

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

By: _____
Deputy County Counsel

By: _____
Deputy

Date: _____

Date: _____

APPROVED AS TO FORM AND CONTENT:
ANN DETRICK, PHD

APPROVED AS TO FORM:
RISK MANAGEMENT

By: _____
Department Director

By: _____
Risk Management

Date: _____

Date: _____

FIRST AMENDMENT 2009-2010

Contract Summary

BC# BC 05-131

D1. Fiscal Year: FY 09-10
 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*): Personal Service Capital Project/Construction
 K2. Brief Summary of Contract Description/Purpose: Children's Psychiatrist Santa Barbara
 K3. Original Contract Amount: \$187200
 K4. Contract Begin Date: 7/1/2009
 K5. Original Contract End Date: 6/30/2010
 K6. Amendment History (*leave blank if no prior amendments*):

<u>Seq#</u>	<u>EffectiveDate</u>	<u>ThisAmndtAmt</u>	<u>CumAmndtToDate</u>	<u>NewTotalAmt</u>	<u>NewEndDate</u>	<u>Purpose(2-4 words)</u>
1	12/8/09	\$-60360	\$-60360	\$126840	6/30/10	Decrease to 0.5 FTE

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: \$126840
 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*): EID#9343
 V2. Payee/**CONTRACTOR** Name: Kellee Clougherty, MD
 V3. Mailing Address: 11249 N. Ventura Ave.
 V4. City State (*two-letter*) Zip (*include +4 if known*): Ojai, CA 93023
 V5. Telephone Number: 9168036138
 V6. **CONTRACTOR'S** Federal Tax ID Number (*EIN or SSN*): 7619
 V7. Contact Person: Kellee Clougherty, 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: #G79391
 V11. Verified by (*name of County staff*): Erin Jeffery
 V12. Company Type (*Check one*): 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: _____