

EXERCISE OF OPTION TO EXTEND THE TERM

of

AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

between

COUNTY OF SANTA BARBARA

and

AMERICAN MEDICAL RESPONSE WEST

THIS EXERCISE OF OPTION TO EXTEND THE TERM of the Emergency and Non-Emergency Ambulance Service Agreement for Advance Life Support and Pre-Hospital Care, number BC-05-168 (hereafter Agreement), is entered into by and between the County of Santa Barbara (COUNTY) and American Medical Response West (CONTRACTOR), to provide for the continuation of services by CONTRACTOR.

WHEREAS, the current term of the Agreement is effective through December 31, 2011; and

WHEREAS, Section 1.4 of the Agreement provides that the “Agreement may be extended for two (2) subsequent three-year terms”; and

WHEREAS, Section 1.4 of the Agreement states that, “two years prior to the expiration of this Agreement, Contractor shall petition the EMS Agency Director for the option to extend the Agreement”; and

WHEREAS, both parties desire to extend the term of the Agreement for an additional three-year period.

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

Extension.

The Agreement’s term is extended as follows:

SECTION 1 ADMINISTRATION OF THE CONTRACT AND TERMS

1.2 Term of Contract

The term of this Agreement shall commence at 00:01 hours on January 1, 2005 (Effective Date), and shall terminate at midnight on December 31, ~~2011~~ **2014**, unless terminated earlier or extended pursuant to the terms and conditions of this Agreement.

Exercise of Option to Extend Term of Agreement for Services of Independent Contractor between the **County of Santa Barbara** and **American Medical Response West**.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on date executed by COUNTY.

COUNTY OF SANTA BARBARA

ATTEST:
MICHAEL F. BROWN
CLERK OF THE BOARD

Chair, Board of Supervisors

By: _____
Deputy

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

APPROVED
TAKASHI WADA, MD, MPH
DIRECTOR/HEALTH OFFICER
PUBLIC HEALTH DEPARTMENT

APPROVED AS TO FORM:
RAY AROMATORIO
RISK PROGRAM ADMINISTRATOR

By: _____
Director

By: _____
Risk Program Administrator

APPROVED
NANCY LAPOLLA, MPH
EMERGENCY MEDICAL SERVICES
EMS AGENCY DIRECTOR
PUBLIC HEALTH DEPARTMENT

By: _____
EMS Agency Director

Exercise of Option to Extend Term of Agreement for Services of Independent Contractor between the **County of Santa Barbara** and **American Medical Response West**.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective on date executed by COUNTY.

CONTRACTOR

By: _____
AMERICAN MEDICAL RESPONSE WEST

Date: _____

- D1. Fiscal Year.....: FYs 2009-10 through 2013-14
 - D2. Budget Unit Number (plus -Ship/-Bill codes in paren's) : 041
 - D3. Requisition Number: N/A
 - D4. Department Name: Public Health Department
 - D5. Contact Person.....: Nancy Lapolla
 - D6. Phone: 681-5264
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- K1. Contract Type (check one): Personal Service Capital Project/Construction
 - K2. Brief Summary of Contract Description/Purpose.: Emergency and Non-Emergency Ambulance Service
 - K3. Original Contract Amount: \$
 - K4. Contract Begin Date.....: January 1, 2005
 - K5. Original Contract End Date: December 31, 2011
 - K6. Amendment History (leave blank if no prior amendments):

<u>Seq#EffectiveDateThisAmndtAmtCumAmndtToDateNewTotalAmtNewEndDate</u>	<u>Purpose (2-4 words)</u>
17-13-10	Exercise to Renew Agreement through December 31, 2013
 - K7. Department Project Number.....: N/A
-

- 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): \$N/A
 - B5. If Board waived bids, show Agenda Date: N/A
 - B6. ... and Agenda Item Number: #N/A
 - B7. Boilerplate Contract Text Unaffected? (Yes / or cite ¶¶) :
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- F1. Encumbrance Transaction Code: 1701
 - F2. Current Year Encumbrance Amount.....: \$
 - F3. Fund Number.....: 0042
 - F4. Department Number: 041
 - F5. Division Number (if applicable):
 - F6. Account Number:
 - F7. Cost Center number (if applicable).....:
 - F8. Payment Terms: Net 30
-

- V1. Vendor Numbers (A=uditor; P=urchasing).....:
- V2. Payee/Contractor Name.....: American Medical Response West
- V3. Mailing Address: 240 E. Highway 246, Suite 300
- V4. City State (two-letter) Zip (include +4 if known) : Buellton, CA 93427
- V5. Telephone Number: 805-688-6550
- V6. Contractor's Federal Tax ID Number.....: On File
- V7. Contact Person.....: Doug Petrick
- V8. Workers Comp Insurance Expiration Date.....: N/A
- V9. Liability Insurance Expiration Date[s] (G=enl; P=rofl) : 3/31/11
- V10. Professional License Number.....: #N/A
- V11. Verified by (name of County staff).....: Rose Davis, 681-5107
- V12. Company Type (Check one): Individual Sole Proprietorship Partnership Corporation

I certify: information complete and accurate; designated funds available; required concurrences evidenced on signature page.

Date : _____ Authorized Signature_____