# DEPARTMENT OF PUBLIC HEALTH
# AGREEMENT OF UNDERSTANDING
# INSTRUCTION

**USE:**

The Agreement of Understanding (AOU) form is a two (2) page form that is to be completed by the employee, and witnessed by the employee's supervisor, at the time the employee's supervisor meets with the employee to discuss the employee's annual Performance Evaluation.

**PROCEDURE:**

**Completing the AOU form:**

- The employee's supervisor discusses and reviews with the employee the policies listed on the AOU.
  (Note: All of the listed policies are included in the Performance Evaluation Policy Packet, located on the PHD Intranet Website, in the Forms subsection. If required, any or all of the policies can be printed out from this website)
- The employee completes the employee information at the top of the first page of the AOU.
- The employee and the employee's supervisor shall each sign and date at the bottom of the first page.
- The employee shall initial and date, in the applicable column, next to each listed policy.
- The employee's supervisor validates, if applicable, that the employee's license, certificate, or registration is current and valid. The supervisor should utilize the issuing agency's website for Primary Source Verification and attach a copy to the AOU. A copy of the physical license, registration or registration can be attached to the AOU, if the website verification is not accessible.
- The employee's supervisor, if applicable, will verify by direct observation, that an employee who has been issued a Deputy Health Badge, is in possession of the badge.
- The employee's supervisor completes, if applicable, the “Verification of License, Certificate or Registration, or Deputy Health Badge” Section on Page 1.
- The employee completes the “Current Home Address and Telephone Number”, Section on Page 2.
- The employee completes the “Emergency Contact Information” on Page 2.
- The employee completes, at his/her option, the “Choice of Physician for Industrial Injury/Illness” Section on Page 2.
- The employee shall sign and date the bottom of Page 2.
- The employee's supervisor shall sign and date the bottom of Page 2.

**DISTRIBUTING THE AOU:**

- The supervisor makes two (2) copies of the AOU.
- The original of the AOU is attached to the original of the employee's Performance Evaluation and both are submitted to DPH Human Resources.
- A copy of the AOU is attached to a copy of the employee's Performance Evaluation for the employee's area file.
- A copy of the AOU is attached to a copy of the employee's Performance Evaluation and both are given to the employee.

COUNTY OF LOS ANGELES . DEPARTMENT OF PUBLIC HEALTH

**HUMAN RESOURCES**

# AGREEMENT OF UNDERSTANDING . ANNUAL

| NAME (Please PRINT Last, First): | Employee Number: | Program Name: |
|---|---|---|
| Job Classification: | Item Number: | Department Pay Location: |

| DPH POLICY/GUIDELINE | TITLE | EMPLOYEE INITIALS / DATE | |
|---|---|---|---|
| 325 | Hand Hygiene in Healthcare Settings | | |
| 610, 611, 612 | Time Reporting | | |
| 701 | Possession of a License or Certificate | | |
| 704 | Professional Appearance in the Workplace | | |
| 714 | Identification Badges | | |
| 722 | Nepotism | | |
| 723 | Designation of Sensitive Positions and Requirements for Criminal History Information | | |
| 728 | Capping | | |
| 729 | Political Activity | | |
| 746 | Threat Management "Zero Tolerance" Policy | | |
| 748 | Diversity Policy | | |
| 762 | Attendance Policy | | |
| 763 | Overtime | | |
| DHR 812 | County Policy of Equity | | |
| 911 | Role of DPH Employees in the Event of an Emergency | | |
| 1000 | Public Health Information Technology and Security Policy | | |
| 1016 | Acceptable Use Policy for County Information Technology Resources | | |
| —— | Child Abuse Reporting, Elder/Dependent Adult Abuse Reporting, Domestic/Intimate Partner Violence Reporting, Sexual Abuse/Sexual Coercion/Sexual Misconduct, Reporting Suspicious Injuries | | |
| —— | Guidelines: Navigating the Discipline Process | | |

* Numbered policies are accessible online for review and/or download on the DPH website under: Policies & Procedures. For additional County policies visit:**http://countypolicy.co.la.ca.us/**

**VERIFICATION OF: LICENSE, CERTIFICATE, REGISTRATION, OR DEPUTY HEALTH BADGE**

**LICENSE, CERTIFICATE, 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, suspension or discharge from County service. Upon request by a supervisor/manager, the employee must provide the original documentation for verification. If there is a change in status of the license/certificate/registration, the employee must immediately notify his/her supervisor. If applicable, the primary source verification printout from the website of the issuing authority must be attached to this PE. If the website is inaccessible, a copy of the current applicable license, certificate and/or registration must be attached.

**BADGE:** If an employee has been issued a Deputy Health Badge needed to enforce public health regulations, the badge must be presented at the time of the annual PE and the badge number noted below.

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

I acknowledge that I have read and reviewed the listed policies/guidelines and will comply with them in my work environment. I understand that if at any time during my employment I have questions or concerns regarding these policies/guidelines they shall be directed to my chain of command or to the DPH Human Resources Office. I am aware that if I violate the above policies/guidelines I will be subject to non-disciplinary and/or disciplinary action up to and including warning, reprimand, suspension, and/or discharge from County employment.

_____ / _____

Employee's Signature — Date

_____ / _____

Witnessed by: Supervisor's Signature — Date

COUNTY OF LOS ANGELES ▪ DEPARTMENT OF PUBLIC HEALTH

## HUMAN RESOURCES

# ANNUAL AGREEMENT OF UNDERSTANDING

**(Continued)**

### EMPLOYEE'S CURRENT ADDRESS/TELEPHONE NUMBER

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

| | | |
|---|---|---|
| Employee Name: | Employee No.: | Work Telephone No.: |
| Home Address: | Street | Home/Cell Telephone No. |
| City | State | Zip Code |
| Mailing Address | | Optional Telephone No. |

### 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. (A change of Physician/Medical Group form Is available in DPH Human Resources.)

| **(MUST BE COMPLETE) DECLARATION OF CHOICE OF PHYSICIAN IN CASE OF INDUSTRIAL INJURY/ILLNESS *(PLEASE PRINT)*** | |
|---|---|
| PERSONAL PHYSICIAN/MEDICAL GROUP'S NAME | PHYSICIAN/MEDICAL GROUP'S PHONE #<br>(  ) |
| 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** |
|---|---|
| | |

### EMERGENCY CONTACT INFORMATION

Please complete the following information about someone to contact in case you are involved in an emergency (All information is required, if information is missing, Emergency Contact Information will not be updated):

| | |
|---|---|
| #1 Person To Notify (Full Name): | Relationship: |
| Home Telephone No.: | Work/Cell Telephone No.: |
| Home Address: | City, State, Zip: |
| #2 Person To Notify (Full Name): | Relationship: |
| Home Telephone No.: | Work/Cell Telephone No.: |
| Home Address: | City, State, Zip: |

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

| EMPLOYEE'S SIGNATURE | DATE |
|---|---|
| _____ | _____ |

| SUPERVISOR'S SIGNATURE | DATE |
|---|---|
| _____ | _____ |

**Distribution:**

#1 Original: Official Employee Personnel Folder in DPH HR at
5555 Ferguson Drive, 2nd Floor, Suite 220, Commerce, CA 90022

#2 Copy to Supervisor for Area File

#3 Copy to Employee