



Employee Name _____

Job Title _____

Employee ID # _____

Health Policy A-14

Attachment 1: Employee Statement Regarding Conflicts of Interest, Incompatible Activities, and Outside Employment

Instructions:

- You are required to fill out this form **only** if (1) you have an existing reportable conflict of interest and/or outside employment (“conflict”) according to [Policy A-14, Conflict of Interest, Incompatible Activities and Outside Employment for Employees of County of San Mateo Health \(Policy A-14\)](#); or (2) you are planning to engage in a job or activity that could be a reportable conflict, and need the conflict to be cleared prior to starting.
- Once you have completed the form, please submit the form to your supervisor for their signature. Your supervisor will submit your form to your division director, who will obtain the Health Chief’s approval if necessary, before returning the completed form to you with all required signatures (which can be in digital format). As a final step, please email a copy of the signed form to your division’s [Payroll/Personnel Coordinator](#), no later than **30 days** after receiving the request to complete your annual conflict of interest / outside employment attestation via Workday.
- If you are a new employee **who has a conflict** and it has been less than 12 months since you completed this form, please fill in **highlighted** section immediately below; you do not need to complete the rest of the form again. Once you check the box and fill in your name/date below, please email it directly to your [Payroll/Personnel Coordinator](#) for filing.

YES, I am a new employee, with a reportable conflict, and have already submitted this form within the last 12 months; my situation has not changed since my original submission.

Your Name: _____ Date: _____

- If you have any other questions about this form, please contact HealthAdmin@smcgov.org.

1) EMPLOYEE'S EXPLANATION OF THEIR CONFLICT OF INTEREST AND/OR OUTSIDE EMPLOYMENT

Please review and select the item(s) that apply to your situation below:

- A.** I am a *full-time employee* who is currently engaged in outside employment, activity and/or enterprise which is (a) not prohibited by the policies and (b) for less than 20 hours a week.

Average number of hours per week engaged in the allowable outside employment, activity, and/or enterprise: ____

Description of the outside employment, activity, or enterprise, including the name and address of employer:

- B.** I am a *part-time/extra help employee* currently engaged in outside employment which is (a) not prohibited by the policies and (b) my combined outside and County employment is less than or equal to 60 hours a week. I currently work an average of ____ hours per week for the County.

Average number of hours per week engaged in the allowable outside employment, activity, and/or enterprise: ____

Description of the outside employment, activity, or enterprise, including the name and address of employer:

- C.** I am planning on or am currently engaged in outside employment, activity or enterprise which is prohibited by the policies, and I am requesting to be exempted from the policies.

If you selected C above, please describe below the outside employment, activity, or enterprise for which an exemption is sought, including name and address of employer and reasons for the exemption. If you are a part-time / extra-help employee, please note the average number of hours per week that you work for the County.

- D.** I have previously received written approval of the Chief of County Health to be employed in a non-County position or to be involved in an activity or enterprise that is prohibited. (Please attach a copy of the written approval).
- E.** I have activities, relationships, interests, and/or financial interests that (1) are a possible conflict of interest per *Policy A-14*, and that (2) are not covered in A, B, C, or D above.

If you selected E above, please explain in detail the activity, relationship, interest, or financial interest being reported. If you are a part-time / extra-help employee, please note the average number of hours per week that you work for the Count

2) EMPLOYEE ATTESTATION

I have read Policy A-14 and attest that the above information is correct to the best of my knowledge.

Your Signature: _____ Date: _____

3) SUPERVISOR APPROVAL

Action on requested approval: Approve Disapprove

Supervisor's Signature: _____ Date: _____

Supervisor's Name: _____

4) DIVISION DIRECTOR APPROVAL

Action on requested approval: Approve Disapprove

Your division: _____

Division Director's Signature: _____ Date _____

Comments:

5) HEALTH CHIEF APPROVAL: Required if 1C or 1E are checked above, AND Supervisor and Director (Sections 3 and 4) have approved the request.

Please email this form to HealthChiefApproval@smcgov.org for the Chief's approval

Action on requested approval: Approve Disapprove

Comments:

Signature of Chief of County Health

Date