



*ValleyCare* Olive View – UCLA Medical Center  
Affiliated Schools Program

## **2011 Human Resource Package**

### **Instructions:**

1. Call Human Resource to make your appointment for fingerprint and processing:  
818-364-3311
2. Complete this package before you go to your appointment.
3. When completing the forms, use the name on your drivers' license. Do not use nicknames.
4. Make sure you take with you to Human Resource your driver's license for identification on the day of your appointment.

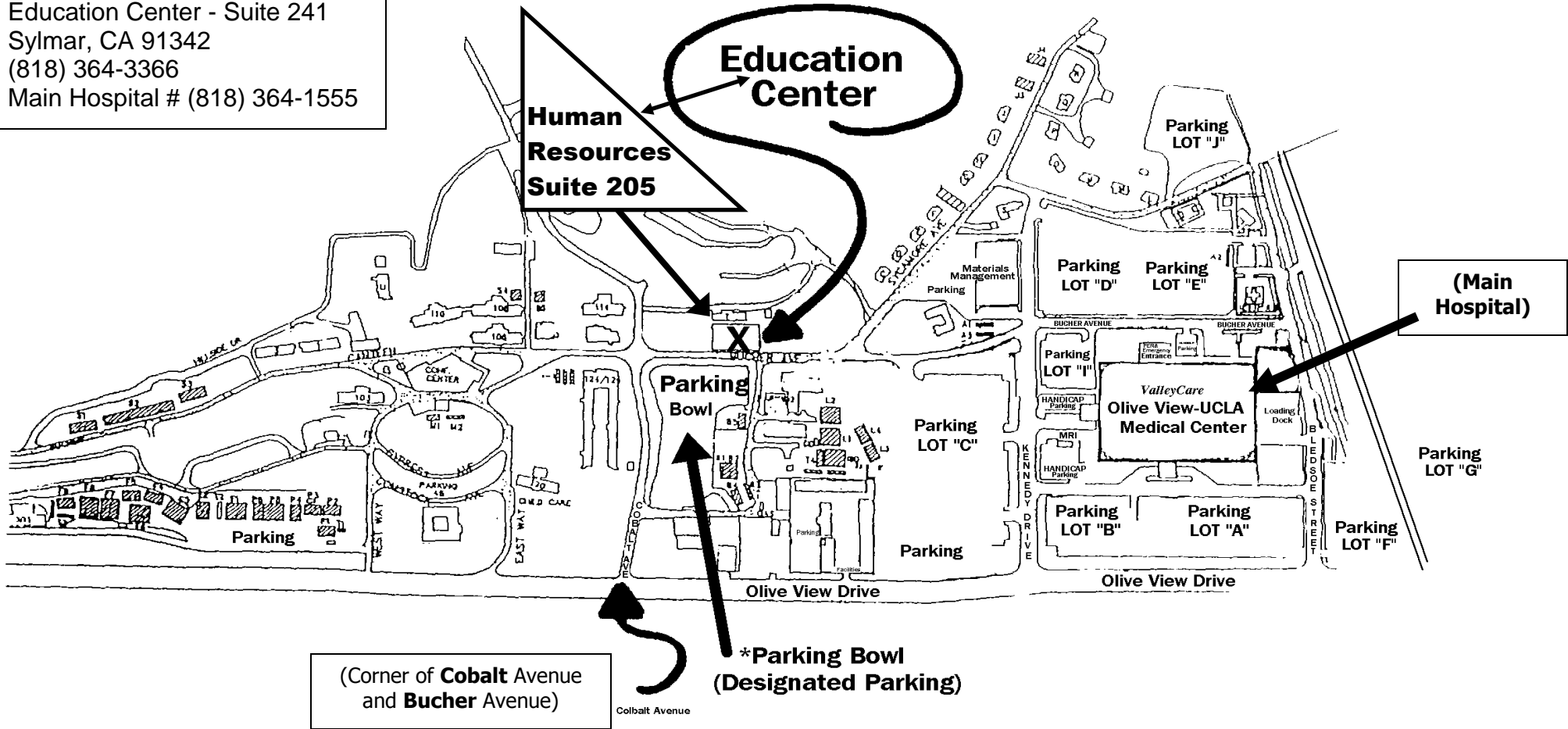
Thank You

# ValleyCare

## Olive View-UCLA Medical Center

### Department of Education

14445 Olive View Dr.  
 Education Center - Suite 241  
 Sylmar, CA 91342  
 (818) 364-3366  
 Main Hospital # (818) 364-1555



West of the main Hospital Building is Cobalt Avenue (off Olive View Drive, Cobalt towards the mountains). A large parking area is immediately on your right. At the far end of the parking areas are two staircases leading up to a two-story white building - the ValleyCare Education Center.

**The Education Center is located on Olive View grounds not in the main hospital.** (Please refer to map for directions.)



**LOS ANGELES COUNTY  
DEPARTMENT OF HEALTH SERVICES**

New Hire     Promotion     Transfer     Non-County Staff

**INFORMATION SHEET**

1 LAST NAME	FIRST NAME	MIDDLE NAME	Social Security Number  / /
2 RESIDENCE-Street and Number		City and Zip Code	
4 Since (date)		Telephone	
5 Date of Birth	6 Date residency established	California	L A County
7 In case of emergency, notify:		Telephone	
Street and Number		City	
8a. Do you claim Veteran's Credit? Yes _____ No _____ If yes, complete 8b			
8b Military Service in the Armed Forces of the United States		From	To
Highest Rank or Rating		Serial Number	
Branch		Type of Discharge	

3 Do you have a relative currently employed by the County?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Indicate Name, Relationship And Department below:

9 List office and shop machines you can operate:

10 List heavy equipment you can operate?

11 If the position for you are applying requires operating a vehicle on the job, please furnish:		OPERATORS OR CHAUFFEURS LICENSE SERIAL NO				Expiration Date		
12 Foreign Languages	Read	CHECK Write	Speak	13 EDUCATION Name and Location of School	Last Grade Completed	Date Completed	College Major	Degrees
Spanish				Grammar and High School				
French				Other				
Other				Other				

14 Professional or Technical Licenses, Permits, etc (Show state, county or city in which registered):

15 Have you ever been convicted of a misdemeanor or felony in any court (including traffic court)?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If, "Yes" give the following information for each offense (use additional sheets if necessary):

DATE OF CONVICTION	POLICE DEPARTMENT OR COURT	CHARGE	DISPOSITION

**PRIOR CONVICTIONS WILL NOT AUTOMATICALLY BAR EMPLOYMENT; HOWEVER, FAILURE TO FULLY AND ACCURATELY DISCLOSE PRIOR CONVICTIONS MAY CONSTITUTE GROUNDS FOR DISQUALIFICATION AND/OR IMMEDIATE TERMINATION.**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ SOCIAL SECURITY NO \_\_\_\_\_

DATE OF CONVICTION	POLICE DEPARTMENT OR COURT	CHARGE	DISPOSITION

16 Have you ever been convicted of a crime under a different name (or names)? If so, please list

17 Have you worked for Los Angeles County? If so, please provide Employee No and Department(s) worked

18 If you have worked for Los Angeles County under a different name (or names), please list

19 I am willing to work the following shifts:  
 \_\_\_\_\_ (1) Day Shift \_\_\_\_\_ (2) Night Shift \_\_\_\_\_ (3) Swing Shift \_\_\_\_\_ (4) Weekend Shift

20 Remarks (Identify by box number)

21. EMPLOYMENT HISTORY: Begin with present or last experience Account for past ten years or past ten employers

From Mo-Yr	To Mo-Yr	Time In Mos	Position or Occupation	Duties performed in each employment	Wages or Salary	Name and addresses of all former employers including other County depts As well as private firms.	Reason for Leaving

If discharged, give detail (REQUIRED):

22 I CERTIFY THROUGH MY SIGNATURE THAT ALL STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

PRINT NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PERSONNEL USE ONLY**

DATE OF LIVE SCAN \_\_\_\_\_

RESULTS  
 CLEAR  Date \_\_\_\_\_

PM  Date \_\_\_\_\_  
 ACCEPTABLE  UNACCEPTABLE  Date \_\_\_\_\_

DATE OF PHYSICAL \_\_\_\_\_

DATE OF CLEARANCE \_\_\_\_\_

I CERTIFY THROUGH MY SIGNATURE THAT I HAVE REVIEWED THIS FORM FOR COMPLETION

\_\_\_\_\_  
 SIGNATURE -- HR REPRESENTATIVE

\_\_\_\_\_  
 PRINT NAME DATE



**Health Services**  
LOS ANGELES COUNTY

Los Angeles County  
Board of Supervisors

Gloria Molina  
First District

Mark Ridley-Thomas  
Second District

Zev Yaroslavsky  
Third District

Don Knabe  
Fourth District

Michael D. Antonovich  
Fifth District

John F. Schunhoff, Ph.D.  
Interim Director

Robert G. Splawn, M.D.  
Interim Chief Medical Officer

DHS Human Resources  
5555 Ferguson Drive, Suite 120-27  
Commerce, CA 90022

Tel: (323) 869-7135  
Fax: (323) 869-0374

[www.dhs.lacounty.gov](http://www.dhs.lacounty.gov)

*To improve health  
through leadership,  
service and education*



[www.dhs.lacounty.gov](http://www.dhs.lacounty.gov)

DATE: \_\_\_\_\_

TO: \_\_\_\_\_

FROM: \_\_\_\_\_

**NON-COUNTY ASSIGNMENT - BACKGROUND INVESTIGATION  
AND MEDICAL EXAMINATION**

This is to advise you that your assignment with the Department of Health Services is contingent upon you passing a Live Scan criminal background investigation and clearance of a health screening

Once these clearances are obtained, a start date for your assignment will be established

**Acknowledgment:**

**My signature below certifies that I was advised of and understand the above requirements.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

GK - 6/10/09

c: Personnel File

County of Los Angeles - Department of Health Services  
Human Resources

**BACKGROUND INVESTIGATION POLICY**

As part of its background review, the County of Los Angeles live scans all new hires, current County employees who transfer or promote to sensitive positions, and non-County personnel who work in sensitive positions. We receive criminal history information from the State of California Department of Justice Bureau of Criminal Identification and Information (DOJ). Any such information received from the DOJ that has not been disclosed by the applicant/employee on the employment application and/or Information Sheet may constitute grounds for discipline, up to and including discharge. Non-County personnel who fail to disclose criminal history information may be disqualified from the assignment and deemed unacceptable for service.

Applicant/Employee Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_

6/10/09



## **CONVICTION DISCLOSURE INSTRUCTIONS**

- 1 Traffic misdemeanor/felony convictions include the following: D U I , Reckless Driving, Driving Without License, Driving While License Suspended, etc
- 2 Convictions are PERMANENT and they will show up on your criminal background report even after 10 years.
- 3 Having convictions does not automatically disqualify you as a candidate, but failure to disclose ANY conviction WILL result in automatic disqualification
- 4 If you have any doubt about your criminal history, do not complete any forms until you have obtained your own criminal background results from the California Department of Justice (DOJ) Instructions on requesting your own criminal records can be found at <http://ag.ca.gov/fingerprints/security.php>

I have read these instructions and I understand them completely

Signature \_\_\_\_\_ Date \_\_\_\_\_

**REQUEST FOR LIVE SCAN SERVICE**

BCB 8016 (3/07)

**Clear Form**

**Applicant Submission**

ORI: \_\_\_\_\_ Type of Application: \_\_\_\_\_  
Code assigned by DOJ

Job Title or Type of License, Certification or Permit: \_\_\_\_\_

Agency Address Set Contributing Agency:

Department of Health Services		06096
<small>Agency authorized to receive criminal history information</small>		<small>Mail Code (five-digit code assigned by DOJ)</small>
5555 Ferguson Avenue	Trinidad Ayala	
<small>Street No Street or PO Box</small>	<small>Contact Name (Mandatory for all school submissions)</small>	
Commerce	CA	90022
<small>City State Zip Code</small>	( 323 ) 890-8328	
		<small>Contact Telephone No</small>

Name of Applicant: \_\_\_\_\_  
(Please print) Last First MI

Alias: \_\_\_\_\_ Driver's License No: \_\_\_\_\_  
Last First

Date of Birth: \_\_\_\_\_ Sex:  Male  Female Misc No BIL - \_\_\_\_\_  
Agency Billing Number

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Misc Number: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street No Street or PO Box

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_  
City, State and Zip Code

Place of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Your Number: \_\_\_\_\_  
OCA No (Agency Identifying No)

Level of Service:  DOJ  FBI

If resubmission, list Original ATI Number: \_\_\_\_\_

Employer: (Additional response for agencies specified by statute)

Employer Name \_\_\_\_\_

Street No	Street or PO Box	Mail Code (five digit code assigned by DOJ)
City	State	Zip Code
		( ) Agency Telephone No (optional)

Live Scan Transaction Completed By: \_\_\_\_\_  
Name of Operator Date

Transmitting Agency \_\_\_\_\_ ATI No \_\_\_\_\_ Amount Collected/Billed \_\_\_\_\_



TO: Workforce Members (County/Non-county)
FROM: Human Resources Manager
SUBJECT: ValleyCare Photo Identification (ID) Badge

Please read the following procedures carefully, as specified in DHS Policy 940:

- 1 Your ID badge must be prominently displayed at all times while on duty on County premises. Personnel failing to display their ID badge shall identify themselves upon request to any employee.
2 It is your responsibility to report a lost/stolen ID badge within five (5) business days to the law enforcement agency having jurisdiction where the loss/theft occurred. You must sign an affidavit attesting to the fact that the ID badge was lost/stolen, and provide Human Resources with a copy of the police report along with the replacement cost of the ID badge. Copies of all documents will be filed in your official personnel file.
3 You are required to pay for the replacement of your ID badge if it is not returned, lost, damaged, or destroyed due to personal negligence. Replacement fees for ID badge are as follows:

Table with 2 columns: Replacement type and Fee. Rows include First, Second, and Third identification badge replacement with fees of \$25.00, \$50.00, and \$100.00 respectively.

- 4 Your ID badge must be returned to your supervisor upon termination of employment/assignment. If it is not returned because it is lost/stolen, you must submit a copy of the police report and affidavit. If you do not submit either of the above, the payment of your accrued benefits may be withheld up to three (3) months.

If you state that you have the ID badge but refuse to return it, the payment of your accrued benefits will not be issued until such time as the ID badge is returned.

- 5 Unauthorized use of your ID badge will be cause for severe disciplinary action which could include discharge from County service.

I have read the above procedures and agree to comply with them

Print name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Emp# (if applicable): \_\_\_\_\_

Division/Agency/School: \_\_\_\_\_

Photographer's initials: \_\_\_\_\_ Date: \_\_\_\_\_

Orig: Employee Personnel File



**REQUEST FOR PARKING PERMIT**

***(FOR HUMAN RESOURCES USE ONLY)***

<b><u>REPLACEMENT PARKING PERMITS ONLY</u></b>	
Lot Assignment _____	Previous Gate Card No _____
Gate Card No _____	Previous Hang Tag No _____
Hang Tag No _____	Date Replaced* _____
<input type="checkbox"/> New Employee <input type="checkbox"/> Lost/Stolen <input type="checkbox"/> Broken	*NOIE: If lost/stolen parking card or hang tag is found, a refund of the amount paid may be requested within ten (10) business days

\_\_\_\_\_  
Last Name                      First Name                      Employee #                      Department #/Pay Location                      Work Area

\_\_\_\_\_  
Job Title                      Item#/Subletter                      Work Shift                      Extension

\_\_\_\_\_  
Contract Agency/School Name                      Handicapped Permit # (if applicable, attach copy of permit)

Car/Vanpool    Yes  No                       Car/Vanpool Riders \_\_\_\_\_

Are you on a call-back schedule?    Yes  No     If so, how frequently are you called back? \_\_\_\_\_

	<i>Vehicle License Plate</i>	<i>Year</i>	<i>Make</i>	<i>Model</i>
1				
2				

Hangtags must be visible from the driver's rear view mirror at all times; failure to properly display hangtag may result in a citation

Parking in lots clearly indicated for patients/visitors is prohibited and is subject to citation

There will be a charge assessed for parking permits that are damaged beyond control, lost, or not turned in to Human Resources when employee is no longer employed at ValleyCare Olive View-UCLA Medical Center. Fees are to be paid through the Cashier's Office, located in the main Hospital in Room 2A102.

**REPLACEMENT FEES → \$15.00 for gate card & \$5.00 for hang tag**

I will park only in my assigned parking lot or my overflow lot and I will obey all parking and speed laws while driving on ValleyCare Olive View-UCLA Medical Center grounds or be subject to a citation and when stopped for a moving violation I will be required to show my driver's license, proper vehicle registration, and, in the event of an accident, proof of insurance

I further understand that receiving a parking permit does not guarantee me a parking space and that I will contact Human Resources at ext 3311 with any parking problems or questions

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

COUNTY OF LOS ANGELES

**County of Los Angeles – Department of Health Services  
ValleyCare Olive View-UCLA Medical Center**

**Facility Orientation Attestation Form**

I hereby acknowledge receipt of the ValleyCare Orientation Handbook. I attest by my signature below that I have read and understand the content, and agree to abide by all policies, procedures, rules and regulations as outlined in said handbook

_____	_____	_____
Workforce Member (Print)	Area/Unit	Start Date
_____	_____	
Workforce Member Signature	Date	

cc: Human Resources  
Department Files

**ACKNOWLEDGMENT OF CONDITIONS OF ASSIGNMENT  
(Contract/Registry Staff, Non-County Residents/Fellows/Affiliates, Volunteers, Students)**

I have read the attached policy regarding non-County workforce members and agree to the following conditions of County assignment:

- My sole employer is \_\_\_\_\_, upon which I rely exclusively for payment of salary and any and all other benefits payable to me or on my behalf during the period of this contractual arrangement/assignment. I understand and agree that I am not an employee of Los Angeles County for any purpose and that I do not have and will not acquire any rights or benefits of any kind from the County during the period of my assignment in County Facility(ies)  
I am a     Non-County Resident/Affiliate/Fellow     Contract/Agency Staff     Volunteer     Student
- I understand and agree that I am not an employee of Los Angeles County for any purpose and that I do not have and will not acquire any rights or benefits of any kind from the County during the period of my assignment in County facility(ies)
- Los Angeles County appointment can be terminated, changed, or altered by the County at any time, with or without cause or prior notice. This policy includes and applies to, without limitation, alternation of status, and cannot be changed in any way except by written agreement between myself, the employing/sponsoring entity and an authorized officer of the hospital in which I am assigned
- Scope of Assignment:  
Check one
  - The scope of my assignment involves direct patient care activities for which I will maintain current licensure, certification and/or registration without restriction and provide evidence to the appropriate authorities at the medical center or facility
  - The scope of my assignment does not involve direct patient care duties, although if my assignment requires licensure, certification and/or registration, I will keep it current and without restriction
- Liability insurance and workers compensation are the responsibility of my employer or academic institution, unless otherwise contractually provided, and the County of Los Angeles shall be held harmless and will not defend in any action taken against me as a result of activities within any County facility
- I must be free of communicable disease, including, but not limited to, tuberculosis, hepatitis B, varicella, rubella, and rubeola and provide verifying evidence to the hospital's Occupational/Employee Health Services as a prior condition of my assignment and annually as required by Occupational/Employee Health Services
- I may be required to submit to fingerprinting for a criminal background check from the State Department of Justice or F B I. Any information received from the background check that I have not disclosed may constitute grounds for immediate dismissal or release
- I must complete mandatory orientation processes (i.e., New Workforce Orientation and area/unit based) immediately upon being appointed to my assigned hospital and/or its associated facilities
- The photo-identification badge issued by DHS Human Resources must be worn at all times, as defined in the hospital policies and procedures, and prominently displayed for review by patients, other workforce members and the public. The badge must be returned to the facility Human Resources office during normal business hours or to the assigned area designee during off-shifts (i.e., holidays, after business hours)
- Research activities are confined to the specific requirements of the Institutional Review Board (IRB)-approved project assigned as applicable
- I may not enter into any patient care or work area except as defined in my job description, applicable assignment and/or IRB-approved research project. Exceptions must be approved in writing by the Chief Medical Officer, appropriate Executive staff member, and/or Associate Dean, Graduate Medical Education
- Patient records are confidential documents that shall be kept confidential and never removed from the County facility providing the patient's care. Patient records will not be photocopied without the consent of the patient and the Director of Health Information Management. Access to patient records for research is limited to records required for the specific IRB-approved research project assigned and must be under the direction of the supervisor
- Use of County resources (telephones, facsimile machines, computers, e-mail, Internet, copiers, medical equipment, etc.) is restricted to activities required in my job description and/or appropriately required by the identified assignment
- I declare that I am not currently and will not, for the duration of my tenure as an independent contractor with the County, engage in any paid/unpaid outside activity that is incompatible to or inconsistent with my County assignment
- I will not receive compensation from Los Angeles County for performing my County assignment

Name (printed) and Signature	Staff ID #	Date
I provided the non-County workforce member above with a copy of the Consolidated Policy Statement and this signed Acknowledgment of Conditions of Assignment		
HR Representative Name (printed) and Signature	Dept #	Date