

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

Conflict of Interest Disclosure Form

EMPLOYEE TO COMPLETE UPPER PORTION OF FORM AND SUBMIT TO IMMEDIATE SUPERVISOR

Employee Name: _____ Employee #: _____

DMH Facility/Program: _____ Dept #: _____

Work Address: _____
(Street) (City) (ZIP Code)

Work Phone #: _____ Employee Payroll Title: _____

Immediate Supervisor: _____ Supervisor Phone #: _____

{ } I am currently not engaged in a Conflict of Interest situation.

{ } I am/believe I am engaged in a Conflict of Interest situation.

{ } I believe/know of a Conflict of Interest situation

Describe the Conflict of Interest situation:

NOTE: If the Conflict of Interest situation involves non-County employment, you must obtain prior approval using the Outside Employment reporting form and approval process. Your signature below certifies that the above information is true and complete to the best of your knowledge. Failure to disclose all known Conflict of Interest information accurately will subject you to disciplinary action up to and including discharge from County Service.

Employee Signature: _____ Date: _____

(CONTINUED ON BACK)

I have reviewed the information above and discussed it with the employee. We have agreed to resolve the situation in the following way in order to best protect the interest of the County:

Immediate Supervisor's Signature: _____ Date: _____

Deputy Director' Approval: _____ Date: _____

Distribution:

Original: Personnel File
Employee
Office Personnel File

REH