COUNTY OF SAN MATEO

Equal Benefits Compliance Declaration Form

I Vendor Identification

Name of Contractor: Donnis S. Hobson M.D
Contact Person: Janet Clyde
Address: 3300 Webster Street, Suite 903
Oakland CA 94609
Phone Number: 510-419-0211
Fax Number: 510-419-0140

II Employees

Does the Contractor have any employees? ☒ Yes ☐ No

Does the Contractor provide benefits to spouses of employees? ☐ Yes ☒ No

If the answer to one or both of the above is no, please skip to Section IV.

III Equal Benefits Compliance (Check one)

☐ Yes, the Contractor complies by offering equal benefits, as defined by Chapter 2.93, to its employees with spouses and its employees with domestic partners.
☐ Yes, the Contractor complies by offering a cash equivalent payment to eligible employees in lieu of equal benefits.
☐ No, the Contractor does not comply.
☐ The Contractor is under a collective bargaining agreement which began on ____________ (date) and expires on ____________ (date).

IV Declaration

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct, and that I am authorized to bind this entity contractually.

Donnis S Hobson MD
Signature

Donnis S. Hobson
Name (Please Print)

owner
Title

6/20/2006
Date

ATTACHMENT I

Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as Amended

The undersigned (hereinafter called the "Contractor(s)") hereby agrees that it will comply with Section 504 of the Rehabilitation Act of 1973, as amended, all requirements imposed by the applicable DHHS regulation, and all guidelines and interpretations issued pursuant thereto.

The Contractor(s) gives/give this assurance in consideration of for the purpose of obtaining contracts after the date of this assurance. The Contractor(s) recognizes/recognize and agrees/agree that contracts will be extended in reliance on the representations and agreements made in this assurance. This assurance is binding on the Contractor(s), its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Contractor(s).

The Contractor(s): (Check a or b)

☒ a. Employs fewer than 15 persons.

☐ b. Employs 15 or more persons and, pursuant to section 84.7 (a) of the regulation (45 C.F.R. 84.7 (a), has designated the following person(s) to coordinate its efforts to comply with the DHHS regulation.

____
Name of 504 Person - Type or Print

Donnis S. Hobson M.D.
Name of Contractor(s) - Type or Print

3300 Webster Street, Suite 903
Street Address or P.O. Box

Oakland, CA 94609
City, State, Zip Code

I certify that the above information is complete and correct to the best of my knowledge.

Donnis S Hobson MD
Signature

Owner
Title of Authorized Official

June 20, 2006
Date

*Exception: DHHS regulations state that:

"If a recipient with fewer than 15 employees finds that, after consultation with a disabled person seeking its services, there is no method of complying with (the facility accessibility regulations) other than making a significant alteration in its existing facilities, the recipient may, as an alternative, refer the handicapped person to other providers of those services that are accessible."

COUNTY OF SAN MATEO

San Mateo Medical Center

MEMORANDUM

Date: June 30, 2006

To: Janine Keller, Risk Management/ Pony # EPS 163 Fax # 363-4864

From: Valerie Yv. Woolsey, San Mateo Medical Center/Fax # 2030

Subject: Contract Insurance Approval

CONTRACTOR: Donnis Hobson, MD

DO THEY TRAVEL: No

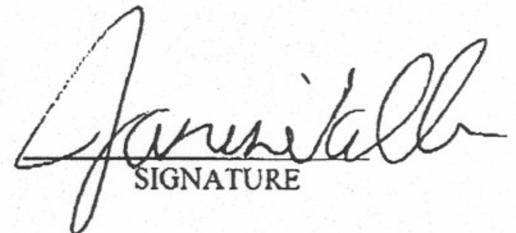
PERCENT OF TRAVEL TIME:

NUMBER O F EMPLOYEES: 0

DUTIES (SPECIFIC): Dr. Donnis Hobson will provide plastic surgery services to San Mateo Medical Center patients.

COVERAGE:	Amount	Approve	Waive	Modify
Comprehensive Liability:	$1/$3m	✓		
Motor Vehicle Liability:		✓	X	
Professional Liability:	$1/$3m	✓		
Worker's Compensation:		✓	X	

REMARKS/COMMENTS:



SIGNATURE

BETA HEALTHCARE GROUP
A Public Entity
CERTIFICATE OF COVERAGE

This is to certify that *Healthcare Entity Comprehensive Liability (including Professional and General Liability)* is in effect for the Named Member named below, subject to the provisions of the Coverage Contract designated.

NAMED MEMBER:	San Mateo County Health Services Agency
RE:	Evidence of Professional Liability Coverage
CERTIFICATE NUMBER:	C-06-068
EFFECTIVE DATE:	7/1/2006 at 12:01 a.m.
EXPIRATION DATE:	7/1/2007 at 12:01 a.m.
RETROACTIVE DATE:	7/1/1994 at 12:01 a.m.
COVERAGE FORM:	Claims Made And Reported

LIMITS OF LIABILITY
Healthcare Entity Comprehensive Liability Coverage

$3,000,000	**Per Claim** (except as provided by Amendment)
$5,000,000	**Annual Aggregate**

DEDUCTIBLE
Healthcare Entity Comprehensive Liability Coverage

$10,000	**Per Claim** (except as provided by Amendment)
NONE	**Annual Aggregate**

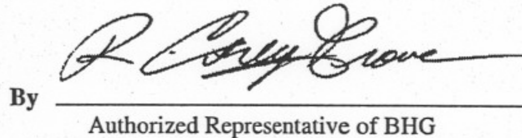
This Certificate is issued as a matter of information only and confers no rights upon the Certificate Holder. This Certificate does not amend, extend or alter the coverage afforded under the Coverage Contract.

CERTIFICATE HOLDER
Donnis Hobson, MD

CANCELLATION

Should the above described Coverage Contract be canceled by BETA HEALTHCARE GROUP before the expiration date thereof, BETA HEALTHCARE GROUP will endeavor to mail 30 days written notice to the Certificate Holder named to the left, but the failure to mail such notice shall impose no obligation or liability of any kind upon BETA HEALTHCARE GROUP, its agents or representatives.

Beta Healthcare Group
1443 Danville Boulevard
Alamo, CA 94507-1973
(925) 838-6070



By ______________________
Authorized Representative of BHG

BETA C.O.C.

Date: July 10, 2006