Contract #: _____

CONTRACT ROUTING SHEET

Date Prepared: 7-3-7 **Need Date:** ASAP

PROCESSING DEPARTMENT:
Department: Human Resources
Dept. Contact: Sherril Jodar
Phone #: 5597
Department Authorization: Human Resources

CONTRACTOR:
Name: Blue Shield Amendment
Address:
Phone:

CONTRACTING DEPARTMENT: Human Resources
Service Requested: Review of Medical Coverage Contract – Blue Shield Amendment
Contract Term: Annual Contract/Amendment Value: $600,000
Compliance with Human Resources requirements? Yes: X No:
Compliance verified by:

COUNTY COUNSEL: (Must approve all contracts and MOU's)
Approved: ✓ Disapproved: Date: 7/2/07 By:
Approved: Disapproved: Date: By:

PLEASE FORWARD TO RISK MANAGEMENT. THANKS!

RISK MANAGEMENT: (All contracts and MOU's except boilerplate grant funding agreements)
Approved: Yes Disapproved: Date: 7-3-7 By: S. Jodar
Approved: Disapproved: Date: By:

OTHER APPROVAL: (Specify department(s) participating or directly affected by this contract).
Departments:
Approved: Disapproved: Date: By:
Approved: Disapproved: Date: By: