

**DEPARTMENT OF HEALTH SERVICES**

**MASTER AGREEMENT NUMBER: \_\_\_\_**

**TASK ORDER # \_\_\_\_**

**<TYPE OF SERVICE>**

**OVERVIEW**

Effective <DATE OF AWARD OF MASTER AGREEMENT>, <NAME OF CONTRACTOR> (“Contractor”) and the County of Sonoma (“Owner”) entered into an Agreement for <TITLE OF MASTER AGREEMENT SERVICES> (the “Master Agreement”). Pursuant to Section 1.1 of the Master Agreement, Contractor and County may execute task orders by which County requests and Contractor agrees to perform certain professional services. This “Task Order # \_\_\_\_” is entered into between County and Contractor pursuant to the Master Agreement for Contractor to provide <DESCRIPTION OF SERVICES> Services for the Sonoma County Department of Health Services. The terms of the Master Agreement shall control all work performed hereunder.

**SCOPE OF SERVICES**

At the direction of the County, Contractor shall provide <DESCRIPTION OF THIS PARTICULAR TASK ORDER SERVICES> Task Order shall include, but are not limited to:

- <BULLETED SOW LIST OF SERVICES PROVIDED>

Contractor shall perform work only upon the express direction of the County.

**COMPENSATION FOR SERVICES**

The County of Sonoma shall compensate <NAME OF CONTRACTOR> for services and associated expenses, provided under this Task Order # \_\_\_\_, on a time-and-materials/expense basis in an amount not-to-exceed <DOLLAR AMOUNT WRITTEN OUT> (\$<DOLLARS>) in accordance with the Contractor’s Billing Rate Schedule included as *Exhibit A, Schedule of Fees*. The fees as stated shall not be exceeded without the prior written authorization from the County.

EXHIBIT 1 to TASK ORDER

<ADD ALL FEDERAL, STATE, FEMA OR OTHER GRANT REQUIRED PROVISIONS TO THIS SECTION WHICH PERTAIN TO THIS PARTICULAR TASK ORDER>

SAMPLE

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the Effective Date.

CONTRACTOR:

\_\_\_\_\_

By: \_\_\_\_\_

Name: \_\_\_\_\_

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

Date: \_\_\_\_\_

COUNTY: COUNTY OF SONOMA

CERTIFICATES OF INSURANCE  
REVIEWED, ON FILE, AND APPROVED  
AS TO SUBSTANCE FOR COUNTY:

By: \_\_\_\_\_

Department Director or Designee

Date: \_\_\_\_\_

APPROVED AS TO FORM FOR COUNTY:

By: \_\_\_\_\_

County Counsel

Date: \_\_\_\_\_

EXECUTED BY:

By: \_\_\_\_\_

Tina Rivera, Director  
Department of Health Services

Date: \_\_\_\_\_

SAMPLE