

STATE OF TEXAS §
 §
 COUNTY OF FORT BEND §

**FIRST AMENDMENT TO AGREEMENT FOR IMMUNIZATION AND TUBERCULOSIS CLINICAL
AND NON CLINICAL SUPPORT FY2025**

THIS FIRST AMENDMENT ("Amendment") is made and entered into by and between **FORT BEND COUNTY**, (hereinafter "County"), a body corporate and politic under the laws of the State of Texas, acting herein by and through its Purchasing Agent, according to Texas Local Government Code § 262.011(d), and **The Reserves Network, Inc.**, d/b/a Team1Medical Staffing, (hereinafter "Contractor"), an entity authorized to conduct business in the State of Texas (hereinafter collectively may be referred to as the "Parties" and each individually a "Party").

WHEREAS, on or about October 18, 2023, the Parties executed and accepted that certain Agreement for Immunization and Tuberculosis Clinical and Non Clinical Support FY2025 (hereinafter "Agreement") which is incorporated by reference as if set forth herein verbatim; and

WHEREAS, by execution of this Amendment, the Parties desire to amend the Agreement to provide additional services by Contractor, to increase the Total Maximum Compensation for completion of such services and to otherwise ratify and confirm all the terms and conditions as set forth herein.

NOW THEREFORE, in consideration of the foregoing, the Parties do mutually agree that the Agreement between the Parties is hereby amended as follows:

1. **Scope of Services.** County shall pay Contractor an additional Twenty-Three Thousand Four Hundred Ten and no/100 dollars (\$23,400.00) for the performance and completion of additional services as described in Exhibit "A-1" attached to this Amendment and incorporated by reference for all intents and purposes.
2. **Limit of Appropriation.** Contractor understands and agrees that the Maximum Compensation payable to Contractor for Services rendered under this Agreement is hereby increased to an amount not to exceed Fifty-Eight Thousand Four Hundred and no/100 dollars (\$58,400.00), authorized as follows:

\$35,000.00	under the Agreement
\$23,400.00	under this Amendment
TOTAL	\$58,400.00

In no event shall the amount paid by County under this Agreement exceed the Maximum Compensation without a County approved change order. Contractor clearly understands and agrees, such understanding and agreement being the absolute essence of this Agreement, that County shall have available the total maximum sum of Fifty-Eight Thousand Four Hundred and no/100 dollars (\$58,400.00) specifically allocated to fully discharge any and all liabilities County may incur under the Agreement.

Contractor does further understand and agree, said understanding and agreement also being of the absolute essence of the Agreement, that the total

Maximum Compensation that Contractor may become entitled to and the total maximum sum that County may become liable to pay to Contractor under the Agreement shall not under any conditions, circumstances, or interpretations thereof exceed Fifty-Eight Thousand Four Hundred and no/100 dollars (\$58,400.00).

3. **Time of Performance.** Time for performance of the Services under this Agreement remains the same and shall terminate on September 30, 2025.
4. **Recitals.** The recitals set forth above are incorporated herein by reference and made a part of the Agreement.
5. **Modifications and Conflict.** Except as modified herein, the Agreement shall remain in full force and effect and has not been otherwise modified or amended. If there is a conflict among documents that make up the Agreement, this Amendment shall prevail with regard to the conflict.

{Remainder of Page Intentionally Left Blank}

{Execution Page Follows}

FORT BEND COUNTY

**THE RESERVES NETWORK, INC. DBA TEAM1MEDICAL
STAFFING**

KP George
KP George, County Judge

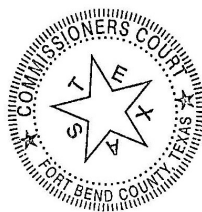
Laura Bowen, CTS/CSP
Authorized Agent – Signature

May 13, 2025
Date

Laura Bowen, CTS/CSP
Authorized Agent – Printed Name

Chief Operating Officer
Title

April 14, 2025
Date



ATTEST:

Laura Richard
Laura Richard, County Clerk

AUDITOR'S CERTIFICATE

I hereby certify that funds are available in the amount of \$ 23,400.00 to accomplish and pay the obligation of Fort Bend County under this contract.

Robert Ed Sturdivant
Robert Ed Sturdivant, County Auditor

i:\agreements\2025 agreements\purchasing\clinical health\the reserves network, inc (25-clnchlth-100196-a1)\1st amendment to agmt w team1medical fy2025 (kcj - 4.14.2025)

EXHIBIT A-1

(Follows Behind)

REQUEST FOR BUDGET CHANGE

Department of State Health Services

Contract Management Section

Contractor Name	Fort Bend County		
Contract Number	HHS001331300020		
Program ID			
Contract Amount	\$258,364		
	Is there an Equipment Cost Change?	AMD not Needed	
	Is there an Indirect Cost Change?	AMD not Needed	
	Is there a decrease in the New Contract Amount?	AMD not Needed	
	Is there an increase in the New Contract Amount?	AMD not Needed	Change Amount Allowed
	Is the percentage over 25%	AMD not Needed	\$64,591

Cost Reimbursement Program						
Category	Approved/Current Budget (Budget Summary Page)	Dollar Change	New Revised Budget (Budget Summary Page)	Categorical Percentage	Cumulative Percentage	
Personnel	\$135,591	(\$5,476)	\$130,115	2%	#1	0%
Fringe Benefits	\$82,336	(\$5,932)	\$76,404	2%	#2	0%
Travel	\$2,749	(\$1,939)	\$810	1%	#3	1%
Equipment	\$0	\$0	\$0	0%	#4	0%
Supplies	\$6,488	(\$135)	\$6,353	0%	#5	6%
Contractual	\$31,200	\$12,510	\$43,710	5%	#6	8%
Other	\$0	\$972	\$972	0%	#7	3%
Indirect Cost	\$0	\$0	\$0	0%	#8	0%
Total	\$258,364	\$0	\$258,364	5%		18%

Changes in either Equipment or Indirect Cost require an Amendment regardless of percentage

FORM I: BUDGET SUMMARY (REQUIRED)

Legal Name of Respondent:

Fort Bend County

Budget Categories	Total Budget (1)	DSHS Funds Requested (2)	Direct Federal Funds (3)	Other State Agency Funds* (4)	Local Funding Sources (5)	Other Funds (6)
A. Personnel	\$130,115	\$130,115	\$0	\$0	\$0	\$0
B. Fringe Benefits	\$76,404	\$76,404	\$0	\$0	\$0	\$0
C. Travel	\$810	\$810	\$0	\$0	\$0	\$0
D. Equipment	\$0	\$0	\$0	\$0	\$0	\$0
E. Supplies	\$6,353	\$6,353	\$0	\$0	\$0	\$0
F. Contractual	\$43,710	\$43,710	\$0	\$0	\$0	\$0
G. Other	\$972	\$972	\$0	\$0	\$0	\$0
H. Total Direct Costs	\$258,364	\$258,364	\$0	\$0	\$0	\$0
I. Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
J. Total (Sum of H and I)	\$258,364	\$258,364	\$0	\$0	\$0	\$0
K. Program Income - Projected Earnings	\$15,000	\$15,000				

NOTE: The "Total Budget" amount for each Budget Category will have to be allocated (entered) manually among the funding sources. Enter amounts in whole dollars. After amounts have been entered for each funding source, verify that the "Distribution Total" below equals the respective amount under the "Total Budget" from column (1).

	Budget Category	Distribution Total	Budget Total	Budget Category	Distribution Total	Budget Total
Check Totals For:	Personnel	\$130,115	\$130,115	Fringe Benefits	\$76,404	\$76,404
	Travel	\$810	\$810	Equipment	\$0	\$0
	Supplies	\$6,353	\$6,353	Contractual	\$43,710	\$43,710
	Other	\$972	\$972	Indirect Costs	\$0	\$0

TOTAL FOR:	Distribution Totals	\$258,364	Budget Total	\$258,364
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*Letter(s) of good standing that validate the respondent's programmatic, administrative, and financial capability must be placed after this form if respondent receives any funding from state agencies other than DSHS related to this project. If the respondent is a state agency or institution of higher education, letter(s) of good standing are not required. *DO NOT* include funding from other state agencies in column 4 or Federal sources in column 3 that is not related to activities being funded by this DSHS project.

CERTIFICATE OF INTERESTED PARTIES

FORM 1295

1 of 1

Complete Nos. 1 - 4 and 6 if there are interested parties.
Complete Nos. 1, 2, 3, 5, and 6 if there are no interested parties.

OFFICE USE ONLY CERTIFICATION OF FILING

1 Name of business entity filing form, and the city, state and country of the business entity's place of business.

The Reserves Network, Inc.
Houston, TX United States

Certificate Number:
2025-1309548

Date Filed:
05/14/2025

Date Acknowledged:
05/14/2025

2 Name of governmental entity or state agency that is a party to the contract for which the form is being filed.

Fort Bend County

3 Provide the identification number used by the governmental entity or state agency to track or identify the contract, and provide a description of the services, goods, or other property to be provided under the contract.

Contract 25-clnchlth-100196-A1
IMMUNIZATION AND TUBERCULOSIS CLINICAL AND NON CLINICAL SUPPORT FY2025

4	Name of Interested Party	City, State, Country (place of business)	Nature of interest (check applicable)	
			Controlling	Intermediary

5 Check only if there is NO Interested Party.



6 UNSWORN DECLARATION

My name is _____, and my date of birth is _____.

My address is _____, _____, _____, _____, _____.
(street) (city) (state) (zip code) (country)

I declare under penalty of perjury that the foregoing is true and correct.

Executed in _____ County, State of _____, on the _____ day of _____, 20____.
(month) (year)

Signature of authorized agent of contracting business entity
(Declarant)