FINANCIAL DISCLOSURE STATEMENT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
SFN 236 (2-2023)

Clear Fields

Name of Governing Body of Which You Are a Member (Agency)

As a member of the above-named agency, I certify that I receive no monetary or other consideration, except reimbursement for actual expenses incurred in the performance of my duties as a board member.

A typed signature is legally binding and equivalent to a handwritten signature.

Signature	Title	Date Signed

The following is a statement of my relationship with the above-named agency in compliance with Sections 75-04-01.21.3, 75-04-01.21.4, 75-04-01.21.5, and 75-04-01.21.6 of the North Dakota Administrative Code:

A typed signature is legally binding and equivalent to a handwritten signature.

Signature	Title	Date Signed