STATE OF NEVADA

ROMAINE GILLILAND

***Director***

Amber Howell

***Administrator***

BRIAN SANDOVAL

***Governor***



**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**DIVISION OF CHILD AND FAMILY SERVICES**

**Children’s Mental Health**

# Acknowledgement Form

**RE:** A-4 False Claims Act Policy (effective 01-27-15)

I acknowledge that I have received, read, and understand the above captioned policy(s) and related attachments.

I understand this signed statement will be placed in my Agency Personnel File.

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Print Employee’s Name Employee’s Signature

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Date

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Supervisor’s Signature Date