rayment to Agency	Report	A Public Do	cument			MENT TO AGENCY REPOR
1. Agency Name				Date Sta	ımp C	alifornia 201
Department of Healtl	h Care Services					Form OU
Division, Department, or R	Region (if applicable)	102				For Official Use Only
Administration Division	on, Human Resou	rces Branch				
P.O. Box 997411, M	S 1300					
Area Code/Phone Number				E		
(916) 552-8270		rest@dhcs.ca.g	YOY	☐ Amendme	ent (explain in co	mment section)
Agency Contact (name and t		rest@urics.ca.	JOV	Date of Origin		
Conflict of Interest Fi	134				(	month, day, year)
2. Donor Name and Add	ress					
☐ Individual			Other	National Ass	ociation of N	Medicaid Directors
Last Name	First I		M Other		Name	
444 North Capitol St., NV	V, Suite 267	Washington City			DC	20001
	to represent and supp		Vienaknula in	50 states to	State	Zip Code
NAMD's sole function is t If "Other" is marked, describe the en				50 states, ter	ritories & th	e district of Columbi
ii Other is marked, describe the en	my s business activity (ii busine	ess) of its nature and inte	esis.			
If applicable	e, identify the name of ea	ach source and the	amount(s) re	eceived by the o	donor for this	payment:
Manufacture and the second	\$					\$
Name		Amount		Name		Amount
3. Payment Information			.2, 3.3)			10 804 W C 842
3.1 (a) Travel Payment	Washington, D			<b></b> )	11/11/18 -	TO ASSES BY MODELLING
Delta Airlines	L.	ocation of Travel				(month, day, year)
Transportation Provide	Rail	☑ Air ☐ Bus		□ Other	Washingto	
624.18	_ 119.00	Check Applicable Box		45.00		of Lodging Facility
\$Lodging Expenses	\$Meal Expenses	\$ 688.05 Transportation Expe	35	15.00 Other Expenses	\$_	1,446.43 Total Expenses
3.1 (b) Payment(s) not i		Transportation Expe	11303	AND DESCRIPTION OF THE PROPERTY OF THE PROPERT		Total Expenses
o. I (b) I ayment(s) not i	related to travel.		Dates (month, d	fay, year)	The same as we say the same and	otal Expenses
3.2. Payment Description	on. Provide a specif	ic description of	thể payme	ent and its ac	iency purpo	se and use.
To attend the 2018 F					,y	
To attend the 2010 f	all MAIND MEETING	g iii vvasiiiigtoi	1, DC			
3.3. Identify the officials	s who used the navn	nant in Section 3	1 /Continue	ational		
	CO 10 20 20 20 20 20 20 20 20 20 20 20 20 20				11111.	0
Cantwell  Last Name	Mari First Name		Chief Deput	tion/Title		Care Programs
Last Name	Filst Name		POSI	lion/Title	!	Department/Division
Ð						
Last Name	First Nam	e	Posi	ition/Title		Department/Division
		<i>(</i> *)				
l. Verification						
l. Verification	ne reported pay	ment(s) as in con	npliance wi	th FPPC regu	lations.	
l. Verification	ne reported pay Erika Sperb			th FPPC regu		1 14 19

(Use this space or an attachment for any additional information)

rayment to Agency R	eport A Publ	ic Document	t .	PAYMENT TO AGENCY REPORT
1. Agency Name			Date Stamp	California QO1
Department of Health				Form OUI
Division, Department, or Reg	gion (if applicable)			For Official Use Only
Administration Division Street Address	n, Human Resources Brar	nch	_	18
P.O. Box 997411, MS	1300			
Area Code/Phone Number	TEmail			
(916) 552-8270	Conflictofinterest@dbs		Amendment	(explain in comment section)
Agency Contact (name and title	ConflictofInterest@dhc	s.ca.gov	Date of Original F	filing:
Conflict of Interest Filir				(month, day, year)
2. Donor Name and Addre	, <del>-</del>			
	<b>!SS</b>		National Accord	iation of Medicaid Directors
Individual Last Name	First Name	Other	National Associ	Name Name
444 North Capitol St., NW,		ıton	D	
Address	City		Sta	
NAMD's sole function is to	represent and support the Med	dicaid Director's ir	n 50 states, territo	ories & the District of Columbia
If "Other" is marked, describe the entity	's business activity (if business) or its nature	and interests.		
			g _pg 500 00	*
ir applicable, i	dentify the name of each source a	ind the amount(s) re	eceived by the don	or for this payment:
Name	\$Amount			\$
			Name	Amount
	Complete Sections 3.1 (a o	r b), 3.2, 3.3)	ara	(// // // // // // // // // // // // //
3.1 (a) Travel Payment	Washington, DC			1/11/2018 - 11/14/2018
Delta Airlines	Location of frave		14	Dates (month, day, year)
Transportation Provider	Rail 🗸 Air	☐ Bus ☐ Auto	o □ Other	ashington Hilton
624.18	110.00 Check Applic		477.00	Name of Lodging Facility
\$\$	3	\$.	Other Expenses	\$
3.1 (b) Payment(s) not rel	3. San	MORE EXPORTS CO	Other Expenses	iotai Expenses
o. r (b) r dyment(s) not re	ateu to traver.	Dates (month, o	day, year)	Total Expenses
3.2. Payment Description	. Provide a specific descript			Processing and Processing Activities
			one and no agen	cy parpose and use.
To attend the 2016 Fai	I NAMD Meeting in Wash	ington, DC		ib
2.2 Idontification officials				
	vho used the payment in Sec			
Brooks	Sarah	Deputy Dire	ector	Health Care Delivery Sys.
Last Name	First Name	Posi	ition/Title	Department/Division
Last Name	First Name	Pos	ition/Title	Department/Division
	ij :s			COUR Medity (South Conditional Systems Analysis)
I. Verification				
	the reported naves ant/a)	in non-ella-	# EDDO - ' '	
	the reported payment(s) as			ons.
	Erika Sperbeck	Chief	Deputy Director	1.14.19
	Print Name		Title	(month, day, year)
Comment:				
(Use this space or an attachment for	or any additional information)			

Payment to Agency R	eport A Public	Document		P	AYMENT TO AGENCY REPORT
1. Agency Name			Date Stam		California OO4
Department of Health					Form OUI
Division, Department, or Reg					For Official Use Only
Administration Division Street Address	n, Human Resources Brancl	h	+		
P.O. Box 997411, MS	1300		-		
Area Code/Phone Number	Email				
(916) 552-8270	ConflictofInterest@dhcs.	ca.gov	Amendment	(explain in	comment section)
Agency Contact (name and title	)		Date of Original	Filing:	(month, day, year)
Conflict of Interest Filir	ng Officer				(month, day, year)
2. Donor Name and Addre	SS				
☐ Individual			California Asso	ociation o	of Health Plans
Last Name 1415 L St #850	First Name Sacrament	: Serot: 3730364	,	Nar Ca	95814
Address	City	0		tate	Zip Code
The California Association	of Health Plans advocates on bel	nalf of our mem	nber health plans	s before	134. 1344.454
	's business activity (if business) or its nature an				
If applicable in	dentify the name of each source and	the amount(e) re	acaived by the de	nor for thi	a naumant
i applicable,	dentity the name of cach source and	the amount(s) re	scerved by the dor	1101 101 [111	s payment.
Name	\$Amount		Name		\$
3. Payment Information (C	Complete Sections 3.1 (a or b	), 3.2, 3.3)			
3.1 (a) Travel Payment	San Diego, CA		1	0/22/201	18 - 10/23/2018
A CONTRACTOR AND A CONT	Location of Travel			Date	es (month, day, year)
Southwest Airlines	□ Rail □ Air ☑	Bus Auto	o □ Other M		ter Grand Hyatt
Transportation Provider	Check Applicable			Nan	ne of Lodging Facility
\$\frac{325.78}{\text{Lodging Expenses}}\$	23.00 \$ 182.62  Meal Expenses Transportation	\$	5.00 Other Expenses	5	536.40
3.1 (b) Payment(s) not rel	neutro-control control	Lxpenses	Other Expenses		Total Expenses
or (a) i ajimoni(a) not for	atou to traver.	Dates (month, d	lay. year)		Total Expenses
3.2. Payment Description.	. Provide a specific description	of the payme	ent and its ager	ncy purp	ose and use.
	he CAHP annual conference				
Initiative".		o and openin	on modifical	ouro	Joordination
3.3. Identify the officials w	vho used the payment in Section	n 3.1 (See instruc	ctions)		
Cooper	Jacey	Assistant De	eputy Director	Health	Care Delivery Sys.
Last Name	First Name	Posit	tion/Title		Department/Division
Last Name	First Name	Posi	ition/Title	****	Department/Division
I. Verification					
	reported payment(s) as in	compliance wit	th FPPC regulat	ione	
	Erika Sperbeck		Deputy Director		111.10
	Print Name		Title		(month, day, year)
Comment:					V
(Use this space or an attachment for	or any additional information)				
					FPPC Form 801 (Jan/14)

advice@fppc.ca.gov

Payment to Agency Re	port A Publi	c Document		PAYMENT TO AGENCY REPORT
1. Agency Name			Date Stamp	California QO1
Department of Health (			_	Form OUI
Division, Department, or Reg				For Official Use Only
Administration Division Street Address	, Human Resources Bran	ch	2 1 DO	
P.O. Box 997411, MS  Area Code/Phone Number	A STATE OF THE PARTY OF THE PAR			
(916) 552-8270	Email		Amendment (e	explain in comment section)
Agency Contact (name and title)	ConflictofInterest@dhc	s.ca.gov	Date of Original Fi	ling:
Conflict of Interest Filin	g Officer		The state of the s	(month, day, year)
2. Donor Name and Addres	SS .			
☐ Individual			National Associa	ation of Medicaid Directors
Last Name 444 North Capitol St., NW, S	First Name Suite 267 Washingt	ton	DO	Name
Address	City		Stat	
	epresent and support the Med		50 states, territor	ries & the District of Columbia
If "Other" is marked, describe the entity's	business activity (if business) or its nature	and interests.		
→ If applicable, id	lentify the name of each source ar	nd the amount(s) re	eceived by the dono	or for this payment:
8	S			•
Name	Amount		Name	Amount
3. Payment Information (Co		r b), 3.2, 3.3)		
3.1 (a) Travel Payment	Washington, D.C.			/11/2018 - 11/14/2018
Delta Airlines			10/-	Dates (month, day, year)
Transportation Provider	☐ Rail ☑ Air Check Applica	☐ Bus ☐ Auto	Other	ashington Hilton  Name of Lodging Facility
624.18	110.00 \$ 657.14		15.00	_ 1,406.32
Lodging Expenses		tion Expenses \$.	Other Expenses	Total Expenses
3.1 (b) Payment(s) not rela	ited to travel:	11	\$	
3.2 Payment Description	Drovido o opositio descripti	Dates (month, o	end 24 Victoria	Total Expenses
	Provide a specific descripti		ent and its agend	y purpose and use.
To attend the 2018 Fall	NAMD Meeting in Washi	ington, DC		1
3.3 Identify the officials w	ho used the payment in Sec	tion 2 d	S 74	
Cooper  Last Name	Jacey First Name		eputy Director	Health Care Delivery Sys.  Department/Division
	T HOL TSLITTO	1 031	don/ fide	Department/Division
Last Name	First Name	Pos	ition/Title	Department/Division
1 Varification				
4. Verification	the reported naves = 1/-1	la azazatiz	th EDDA	
	the reported payment(s) as			
	Erika Sperbeck Print Name	Chief	Deputy Director	1. [4. [9]
	COLUMN TWANTE		Tide	(month, day, year)
Comment: (Use this space or an attachment fo	r any additional information			
fose mis share of an attachment to	any additional information)			the benefit and the second second second second second

Payment to Agency Repo	ort A Public I	Document		PAYMENT TO AGENCY REPORT
1. Agency Name			Date Stamp	Collice III
Department of Health Care			,	Form OUI
Division, Department, or Region	(if applicable)			For Official Use Only
Administration Division, Historia	uman Resources Branch			
P.O. Box 997411, MS 130	00			
Water Streets Control Streets Street	nail		Amendment (	explain in comment section)
	ConflictofInterest@dhcs.c	a.gov	Data of Ovintual E	W
Agency Contact (name and title) Conflict of Interest Filing C	Officer		Date of Original F	(month, day, year)
2. Donor Name and Address	Allicer			
			California School	ol Nurses Organizations
☐ Individual Last Name	First Name	_ ✓ Other		Name
3511 Del Paso Rd #160	Sacramento		C	
Address	City	rezestero e camo	Sta	
CSNO's mission is to ensure that If "Other" is marked, describe the entity's business.	A CONTROL OF THE PROPERTY OF T		d enhance learnii	ng.
If applicable, identi	fy the name of each source and the	ne amount(s) re	eceived by the done	or for this payment:
Name	\$		N	\$
3. Payment Information (Com	100 XX	2.0.2.0\	Name	Amount
	Baltimore, Maryland	, 3.2, 3.3)	10	)/13/18 -10/17/18
3.1 (a) Haver Fayment	Location of Travel			Dates (month, day, year)
Southwest Transportation Provider	Rail 🛛 Air 🗀 E	Name of the last o	Other Re	enaissance Harbor Place Hote Name of Lodging Facility
20.	Check Applicable I		615.00	2,096.68
\$\frac{873.20}{\text{Lodging Expenses}} \frac{\$\text{116}}{\text{Me}}	5.00 \$492.48 Sal Expenses Transportation E		Other Expenses	S
3.1 (b) Payment(s) not related	I to travel:	Dates (month, d	\$ 0.0	OO Total Expenses
3.2. Payment Description. Pro	ovide a specific description	A WAS STORY AND STORY OF BUILDING	24	45
			2000	
To attend the National Allia 2018 in Baltimore, Marylar with the latest information	nd. The conference provide	des an oppo	rtunity for pro	fessional development
3.3. Identify the officials who	used the payment in Sectior	1 3.1 (See instruc	ctions)	
Lai	Betty	Medi-Cal Cla	aims and Servi	DHCS/SNFD
Last Name	First Name	Posit	ion/Title	Department/Division
Last Name	First Name	Posit	tion/Title	Department/Division
4. Verification				
	ne reported payment(s) as in c	ompliance wit	h FPPC regulation	ons.
	Erika Sperbeck		Deputy Director	1.14.19
	Print Name		Title	(month, day, year)
Comment:				
(Use this space or an attachment for any	y additional information)			

rayment to Agency Re	eport A Public L	Jocument		PAYMENT TO AGENCY REPOR
1. Agency Name			Date Stamp	California 201
Department of Health (				Form OUI
Division, Department, or Reg	ion (if applicable)			For Official Use Only
Administration Division Street Address	, Human Resources Branch			
P.O. Box 997411, MS	1300			
Area Code/Phone Number	Email			
(916) 552-8270	ConflictofInterest@dhcs.ca		Amendment (explain i	n comment section)
Agency Contact (name and title)			of Original Filing: _	
Conflict of Interest Filin	g Officer	-		(month, day, year)
2. Donor Name and Addres	SS .	I		22-15
		Calif	fornia School Nur	ses Organizations
☐ Individual Last Name	First Name	_ ☑ Other —		lame
3511 Del Paso Rd #160	Sacramento		CA	95835
Address	City		State	Zip Code
***************************************	e that school nurses optimize stud		ance learning.	
If "Other" is marked, describe the entity's	business activity (if business) or its nature and i	interests.		
If applicable, id	lentify the name of each source and the	ne amount(s) received	d by the donor for t	his payment:
	\$			\$
Name	Amount		Name	Amount
3. Payment Information (Co	omplete Sections 3.1 (a or b)	, 3.2, 3.3)		
3.1 (a) Travel Payment	Baltimore, Maryland  Location of Travel		Nonemonton communication and c	8 - 10/17/18 ates (month, day, year)
Southwest  Transportation Provider	□ Rail □ Air □ E		Ouici	ance Harbor Place Hot
\$\frac{873.20}{\text{Lodging Expenses}} \text{\$\subseteq}	116.00 \$ 543.57  Meal Expenses Transportation E		r Expenses	\$\frac{2,097.77}{\text{Total Expenses}}
Section of the sectio		xpenses Otne		Iotal Expenses
3.1 (b) Payment(s) not rela	ited to travel:	Dates (month, day, year	\$ 0.00	Total Expenses
3.2. Payment Description.	Provide a specific description	A. C.		
2018 in Baltimore, Mary	Alliance for Medicaid in Educ rland. The conference provid on in research, experience, a	des an opportun	ity for profession	onal development
3.3. Identify the officials w	ho used the payment in Section	1 3.1 (See instructions)		
Garcia	Jose	Disproportionate S	Share Ho: DHC	S/SNFD
Last Name	First Name	Position/Title		Department/Division
Last Name	First Name	Position/Title	<u> </u>	Department/Division
4. Verification				
	e reported payment(s) as in c	ompliance with FDI	PC regulations	
	Erika Sperbeck		( <del>5)</del>	111.10
	Print Name	Chief Depu	Title	1.14.19
	Lundivanie		THE	(month, day, year)
Comment:				
(Use this space or an attachment for	r any additional information)			

Payment to Agency	Report	A Public D	ocument			PAYMENT TO AGENCY REPORT
1. Agency Name				Date St	amp	California OO4
Department of Healt	n Care Services				,	Form OUI
Division, Department, or R						For Official Use Only
Administration Division Street Address	on, Human Reso	urces Branch				
P.O. Box 997411, M				20		
Area Code/Phone Numbe	r Email		***************************************	☐ Amendme	ent (explain i	n comment section)
(916) 552-8270		erest@dhcs.ca	ı.gov			, and the second second
Agency Contact (name and to Conflict of Interest Fi	Second Co.			Date of Origin	ıaı Filing: _	(month, day, year)
2. Donor Name and Add						
	ress			Center for H	lealth Car	re Strategies
☐ Individual ————————————————————————————————————	First	t Name	☑ Other			lame
200 American Metro Blvo	I, Suite 119	Hamilton			NJ	08619
Address	as asserted a two Consessions and	City			State	Zip Code
To promote innovations i				iduals with co	mplex, hi	gh-cost needs
ii Other is marked, describe the en	ny's business activity (if busin	ness) or its nature and in	iterests.			
If applicable	e, identify the name of $\epsilon$	each source and the	e amount(s) re	eceived by the	donor for t	his payment:
	\$					\$
Name		Amount		Name		Amount
3. Payment Information		ns 3.1 (a or b),	3.2, 3.3)		40/07/4/	0 40100140
3.1 (a) Travel Payment	Atlanta, GA	Location of Travel				8 - 10/09/18 ates (month, day, year)
United Airlines			00.000 arcestyles			rd Atlanta Decatur
Transportation Provide	Rail	✓ Air ☐ B Check Applicable B		□ Other	and the second s	ame of Lodging Facility
\$\frac{391.80}{\text{Lodging Expenses}}	C C	498.60	- A			890.40
Lodging Expenses	Ф Meal Expenses	ֆ Transportation Ex	penses \$_	Other Expenses		Total Expenses
3.1 (b) Payment(s) not r	elated to travel:			\$	5	
			Dates (month, d			Total Expenses
3.2. Payment Description						
To attend an in-perso	on meeting as a re	equirement for	a technica	al assistanc	e oppor	tunity for the
Centers for Disease	Control and Preve	ention 6 18 init	tiative.			6
	000 90 10					
3.3. Identify the officials	who used the pay	ment in Section	3.1 (See instruc	ctions)		
Patel	Devki		Medical Cor	nsultant	DHC	CS/MCQMD
Last Name	First Nam	10	Posit	tion/Title	***************************************	Department/Division
Last Name	First Nan	me .	Dooi	tion/Title		
Non-record and conflictions.	ENGLINGI		FOSI	uon nuc		Department/Division
I. Verification						
	e reported pa	yment(s) as in co	mpliance wit	th FPPC regu	lations.	
	Erika Sperb			Deputy Direc		1.14.19
Signature		Print Name		Title		(month, day, year)
Comment:						
(Use this space or an attachmen	it for any additional inform	nation)				
		7.7				FPPC Form 801 (Jan/1

advice@fppc.ca.gov

rayment to Agency Re	Port A Public	c Document		PAYMENT TO AGENCY REPORT
1. Agency Name			Date Stamp	California Q 0 4
Department of Health C	are Services	2 - Carrie -	60	Form OU I
Division, Department, or Regio	on (if applicable)			For Official Use Only
Administration Division, Street Address	Human Resources Brand	ch		2
P.O. Box 997411, MS 1	300			
Area Code/Phone Number	Email		☐ Amondment/s	xplain in comment section)
(916) 552-8270	ConflictofInterest@dhcs	s.ca.gov	**************************************	
Agency Contact (name and title)			Date of Original Fil	ling:(month, day, year)
Conflict of Interest Filing	) Officer			(month, day, year)
2. Donor Name and Address	S			
☐ Individual			Center for Health	n Care Strategies
Last Name	First Name			Name
200 American Metro Blvd, Su Address	uite 119 Hamilton		NJ	
			State	
If "Other" is marked, describe the entity's b	iblicly financed health care, es		uals with comple	ex, high-cost needs
ii Other is marked, describe the entity's t	dismess activity (ii business) of its nature a	and interests.		
If applicable, ide	entify the name of each source an	nd the amount(s) rece	eived by the dono	r for this payment:
	\$			\$
Name	Amount		Name	Amount
3. Payment Information (Co	mplete Sections 3.1 (a or	b), 3.2, 3.3)		
3.1 (a) Travel Payment	Atlanta, GA		10/	/07/18 - 10/09/18
1 L-19 - J. XT-P	Location of Travel			Dates (month, day, year)
United Airlines	□ Rail ☑ Air [	☐ Bus ☐ Auto	Other Co	urtyard Atlanta Decatur
Transportation Provider	Check Applica			Name of Lodging Facility
\$	\$498.60	S		\$ 890.40
N A G	Produced Market State	ion Expenses	Other Expenses	Total Expenses
3.1 (b) Payment(s) not relat	ed to travel:	Dates (month, day,	\$	Total Expenses
3.2. Payment Description.	Provide a enecific description			₩
	*			
Contors for Disease Con	neeting as a requirement	t for a technical	assistance of	pportunity for the
Centers for Disease Cor	ntrol and Prevention 6 18	initiative.		
2.2 11-45 11-65	1.1			
3.3. Identify the officials wh		tion 3.1 (See instruction	ins)	
Armendariz	Sydney	Health Progra	m Specialist	DHCS/Benefits
Last Name	First Name	Position	n/Title	Department/Division
Last Name	First Name	Position	n/Title	Department/Division
4. Verification				
9 DOMONON (CIT)	reported payment(s) as i	in compliance with	EDDC regulation	ne
	12			1 1110
	Erika Sperbeck Print Name	Cnief D	eputy Director	[. [0. [7]
•	riiit Name		Title	(month, day, year)
Comment:				S
(Use this space or an attachment for	any additional information)			***************************************

Payment to Agency R	Report A Public Do	cument	PAYMENT TO AGENCY REPOR
1. Agency Name		Date Stamp	California On 1
Department of Health	Care Services		Form OUI
Division, Department, or Re	gion (if applicable)		For Official Use Only
Administration Division Street Address	n, Human Resources Branch		
P.O. Box 997411, MS	1300		
Area Code/Phone Number	Email	[7] 4	/I
(916) 552-8270	ConflictofInterest@dhcs.ca.g	707	(explain in comment section)
Agency Contact (name and title		Date of Original I	Filing: 01/22/19 (month, day, year)
Conflict of Interest Filin	ng Officer		(month, day, year)
2. Donor Name and Addre	ess		
☐ Individual		Other CA Endowmen	t & CA Health Care Foundation
Last Name	First Name		Name
1414 K St, Ste 5000	Sacramento		CA 95814
Address	City		ate Zip Code
	prevention, public health, the uninsure		cess and related policy areas
If "Other" is marked, describe the entity	's business activity (if business) or its nature and inte	rests.	
If applicable,	identify the name of each source and the	amount(s) received by the dor	nor for this payment:
6: 3.8		, g	
Name	\$	Name	Amount
3. Payment Information (C	Complete Sections 3.1 (a or b), 3	.2. 3.3)	
3.1 (a) Travel Payment	San Diego, CA		1/10/18-11/14/18
o.i (a) Haver ayment	Location of Travel		Dates (month, day, year)
Southwest		H	lilton, San Diego
Transportation Provider	Rail Air Bus	B Mario Morrier —	Name of Lodging Facility
1,181.40	188.72 269.66	859.84	2,499.62
\$ S Lodging Expenses	Meal Expenses Transportation Expe	<u> </u>	S
3.1 (b) Payment(s) not re	lated to travel:	\$	
(a) . aya(o)a	-	Dates (month, day, year)	Total Expenses
3.2. Payment Description	. Provide a specific description of	the payment and its ager	ncv purpose and use.
	ate at the American Public Heal	377	
200 EBS 180 St. 000000 20000 Nomen No. 14	193 0 182 800 000 000	. Table 1	
3.3. Identify the officials	who used the payment in Section 3	.1 (See instructions)	
Lee	Patricia F	Research Scientist, III	Office of the Medical Direct
Last Name	First Name	Position/Title	Department/Division
Last Name	First Name	Position/Title	Department/Division
Eddt Haillo	ENSUNAING	rosition/file	Department/Division
4. Verification			
	reported payment(s) as in con	npliance with FPPC regulat	ions.
	Erika Sperbeck	Chief Deputy Director	2.14.19
	Print Name	Title	(month, day, year)
Comment: Amended to refl	ect correct amount of total expenses.		
(Use this space or an attachment			
Canada abana at attantition	y www.ioriai illivilliation)		EDDC Form On4 / Inn/4