SAN BERNARDINO COUNTY | Behavioral Health

ADVANCE HEALTH CARE DIRECTIVE ACKNOWLEDGMENT FORM

I, _____ acknowledge receipt of
Name (Please Print)

a copy of the Advance Health Care Directive Policy and understand that I must comply with its contents.

_____ _____
Employee Signature Date

_____ _____
Supervisor/Manager Signature Date

cc: Department Employee File
DBH Office of Compliance

_____
Employee ID