Candidate Intention Statement

FILED
AUG 05 2020
KATHLEEN WILLIAMS,
BY [redacted]

CALIFORNIA FORM 501

Check One: ☑ Initial ☐ Amendment (Explain) _____

1. Candidate Information:

NAME OF CANDIDATE (Last, First, Middle Initial)	DAYTIME TELEPHONE NUMBER	E-MAIL ADDRESS
Swanson MD, Paul S.	(916) 932-3391 ( )	paul.swanson@ephc.org

STREET ADDRESS	CITY	STATE	ZIP CODE
[redacted]	Portola	CA	96122

OFFICE SOUGHT / POSITION TITLE	AGENCY NAME	DISTRICT NUMBER if applicable	☑ NON-PARTISAN / PARTY PREFERENCE
Director	Eastern Plumas Health Care District		

OFFICE JURISDICTION

☐ State (Complete Part 2)

☐ City ☑ County ☐ Multi-County _____ (Name of Multi-County Jurisdiction)

_____ (Year of Election)

Check one box: ☑ PRIMARY ☐ GENERAL ☐ SPECIAL RUNOFF

2. State Candidate Expenditure Limit Statement:

(CalPERS and CalSTRS candidates, judges, judicial candidates, and candidates for local offices do not complete Part 2.)

Check one box:

☑ I **accept** the voluntary expenditure ceiling for the election stated above.

☐ I **do not accept** the voluntary expenditure ceiling for the election stated above.

Amendment

○ I did not exceed the expenditure ceiling in the primary or special election held on: ____/____/____ and I accept the voluntary expenditure ceiling for the general or special run-off election.

Mark if applicable:

☐ On ____/____/____ I contributed personal funds in excess of the expenditure ceiling for the election stated above.

3. Verification:

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on 8/4/2020 (Date)

Signature [redacted]

Officeholder and Candidate Campaign Statement - Short Form

FILED

CALIFORNIA FORM 470

Date of election if applicable

☐ Amendment

AUG 05 2020

KATHLEEN WILLIAMS,

[redacted]

1. Statement Covers Calendar Year 20 _____.

2. Officeholder or Candidate Information

NAME OF OFFICEHOLDER OR CANDIDATE

Paul Swanson MD

[redacted]

Portola CA 96122

916-932-3391 paul.swanson@ephc.org

3. Office Sought or Held

OFFICE SOUGHT OR HELD

Director, Eastern Plumas Health Care District

Plumas County

4. Committee Information

List all committees of which you have knowledge that are primarily formed to receive contributions or to make expenditures on behalf of your candidacy.

COMMITTEE NAME AND I.D. NUMBER	COMMITTEE ADDRESS	
No Committee		

5. Verification

I declare under penalty of perjury that to the best of my knowledge I anticipate that I will receive less than $2,000 and that I will spend less than $2,000 during the calendar year and that I have used reasonable diligence in preparing this statement. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

DATE SIGNED 7/31/2020

[redacted]

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