

Candidate Intention Statement

FILED

CALIFORNIA
FORM 501

For Official Use Only

Check One: ☒ Initial

☐ Amendment (Explain) _____

AUG 10 2020

KATHLEEN WILLIAMS,

1. Candidate Information:

NAME OF CANDIDATE (Last, First Middle Initial)

DAYTIME TELEPHONE NUMBER

FAX NUMBER (optional)

EMAIL (optional)

SATCHWELL, LINDA S.

(530) 616-0694

STREET ADDRESS

CITY

STATE

ZIP CODE

[REDACTED]

Gracagle

CA

96103

OFFICE SOUGHT (POSITION TITLE)

AGENCY NAME

DISTRICT NUMBER, if applicable.

☒ NON-PARTISAN OFFICE

DIRECTOR, BOD

EASTERN PLUMAS HEALTHCARE DISTRICT

OFFICE JURISDICTION

(Check one box, if applicable.)

☐ State (Complete Part 2.)

☐ City

☒ County

☐ Multi-County:

(Name of Multi-County Jurisdiction)

2020

(Year of Election)

☒ 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 I am a qualified elector of the State of California and I am not a candidate for any office in any election held on or after the date of filing this statement.

Executed on

8/10/2020

(month/day/year)

Signature

[REDACTED]

Officeholder and Candidate
Campaign Statement -
Short Form

Date of election if applicable:
(Month, Day, Year)

11/03/2020

☐ Amendment (Explain Below)

FILED

AUG 10 2020

KATHLEEN WILLIAMS,

CALIFORNIA
FORM 470

For Official Use Only

1. Statement Covers Calendar Year 20

20

2. Officeholder or Candidate Information

NAME OF OFFICEHOLDER OR CANDIDATE

LINDA SATCHWELL

STREET ADDRESS

[REDACTED]

CITY

Graciele

STATE

CA

ZIP CODE

96103

AREA CODE/DAYTIME PHONE NUMBER

(530) 616-0694

OPTIONAL: FAX / E-MAIL ADDRESS

[REDACTED]

3. Office Sought or Held

OFFICE SOUGHT OR HELD

DIRECTOR, BOARD OF DIRECTORS
EASTERN PLUMAS HEALTH CARE DISTRICT

JURISDICTION (LOCATION)

Eastern Plumas Co.

DISTRICT NUMBER
(IF APPLICABLE)

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

NAME OF TREASURER

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 all 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.

Executed on

8/10/2020

DATE

By

[REDACTED]

Clear Form

Print Form