

**TRUMBULL COUNTY BOARD OF DEVELOPMENTAL DISABILITIES**

**Policy**

**Section 1.4**

**EMPLOYEE ACKNOWLEDGEMENT OF MANUAL**

I hereby acknowledge that a copy of the personnel policies of the Trumbull County Board of DD is available to me for my review.

I understand that if I have any questions about these policies, it is my responsibility to seek clarification from my immediate supervisor. I further recognize that it is my responsibility to know, understand and comply with the policies of the Board.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Position

\_\_\_\_\_  
Date

Adopted: 5/26/98

Updated: 7/24/2012