

St. Clair County Community Mental Health Authority  
**Personal Use of Any Cell Phone**  
**During Paid Working Hours**

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**Employee Acknowledgement**

The undersigned employee acknowledges that he/she has read, understands, and will comply with all terms of Policy 06-001-0160 Personnel: Personal Use of Cell Phone.

Employee Name (Printed): \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Original: Personnel File