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SENATE OF PA
SECRETARY'S OFFICE

THE GOVERNOR



COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE GOVERNOR
HARRISBURG

MEMBER OF THE BOARD OF TRUSTEES OF WERNERSVILLE STATE HOSPITAL

December 9, 2011

To the Honorable, the Senate
of the Commonwealth of Pennsylvania:

In conformity with law, I have the honor hereby to nominate for the advice and consent of the Senate, Jonathan D. Encarnacion, 24 Ravine Drive, Reading 19607, Berks County, Eleventh Senatorial District, for appointment as a member of the Board of Trustees of Wernersville State Hospital, to serve until the third Tuesday of January 2017, and until his successor is appointed and qualified, vice Mark C. Inge, Landisville, resigned.

A handwritten signature in black ink that reads "Tom Corbett".

TOM CORBETT
Governor

STATEMENT OF FINANCIAL INTERESTS
PLEASE PRINT NEATLY

01 LAST NAME FIRST NAME MI SUFFIX
ENCARNACION JONATHAN D

02 ADDRESS City State Zip Code Area Code Phone
24 Ravine Drive Reading PA 19607 610 267-3691

NOTE: IF YOU ARE INCLUDING ATTACHMENTS, DO NOT INCLUDE ANYTHING THAT BEARS YOUR SOCIAL SECURITY NUMBER OR FINANCIAL ACCOUNT NUMBERS.

03 STATUS: Check applicable block or blocks, more than one block may be marked. (See instructions on page 2)
A Candidate (including write-in) C Public Official (Current) D Public Employee (Current) E Check this block if you are filing as a subject
B Nominee C Public Official (Former) D Public Employee (Former) Check this block if you are amending an original filing

04 PUBLIC POSITION OR PUBLIC OFFICE (administrator, member, Commissioner, job title, etc.)
A MEMBER seeking hold held
B seeking hold held

05 GOVERNMENTAL ENTITY in which you are/were an Official, Employee, Candidate or Nominee (e.g., dept, agency, authority, borough, board, commission, county, school district, twp, etc.)
A BC WERNERSVILKE ST. HOSPITAL
B

06 OCCUPATION OR PROFESSION (This may be the same as block 4)
Director, UPMC Health Plan
07 YEAR The information in blocks 8 through 15 below represents financial interests for the PRIOR calendar year indicated: 2011

08 REAL ESTATE INTERESTS (See instructions on page 2) If NONE, check this box.

09 CREDITORS (See instructions on page 2). Creditor (Name and Address) If NONE, check this box.
Name: Address: Interest Rate:

10 DIRECT OR INDIRECT SOURCES OF INCOME including (but not limited to) all employment. (See instructions on pg. 2) ONLY IF NONE, check this block.
Name: UPMC Health Plan Address: 1200 Camp Hill Bypass Suite 100 Camp Hill, PA 17011
Value of Gift:

11 GIFTS (See instructions on page 2) If NONE, check this box.
Source of Gift: Address of Source of Gift: Circumstances (including description) of Gift: Value of Gift:

12 TRANSPORTATION, LODGING, HOSPITALITY (See instructions on page 2) If NONE, check this box.
Source (Name and Address): Value:

13 OFFICE, DIRECTORSHIP OR EMPLOYMENT IN ANY BUSINESS (See instructions on page 2) If NONE, check this box.
Business Entity (Name and Address): Name: UPMC Health Plan Address: 1200 Camp Hill Bypass Suite 100 Camp Hill, PA 17011 Position Held: Director

14 FINANCIAL INTEREST IN ANY LEGAL ENTITY IN BUSINESS FOR PROFIT (See instructions on page 2) If NONE, check this box.
Name and Address of Business: Interest Held:

15 BUSINESS INTERESTS TRANSFERRED TO IMMEDIATE FAMILY MEMBER (See instructions on page 2) If NONE, check this box.
Business (Name and Address): Transferee (Name and Address): Interest Held Relationship Date Transferred:

The undersigned hereby affirms that the foregoing information is true and correct to the best of said person's knowledge, information and belief; said affirmation being made subject to the penalties prescribed by 18 Pa.C.S. §4904 (unsworn falsification to authorities) and the Public Official and Employee Ethics Act, 65 Pa.C.S. §1109(b).
Signature: Enter Current Date: 1/5/12

THIS FORM IS CONSIDERED DEFICIENT IF ANY BLOCK ABOVE IS NOT COMPLETED. MAKE A COPY FOR YOUR RECORDS.