

STATEMENT OF FINANCIAL INTERESTS

SEE INSTRUCTIONS FOR ADDITIONAL DETAILS

01 LAST NAME FIRST NAME MI SUFFIX

S H U M A K E R R O B E R T J

02 ADDRESS office (business or governmental) or home City State Zip Code Area Code Phone

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

03 STATUS Check applicable box or boxes, more than one box may be marked.

A Candidate (Including write-in) C Public Official (Current) D Public Employee (Current) E Check this box if you are filing as a solicitor

B Nominee C Public Official (Former) D Public Employee (Former)

Check this box if you are amending an original filing

04 PUBLIC OFFICE OR PUBLIC EMPLOYMENT (i.e. administrator, member, Commissioner, Job title, etc.) seeking hold held

A seeking hold held

B seeking hold held

05 GOVERNMENTAL BODY 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 ENVIRONMENTAL ADVISORY BOARD

B

06 OCCUPATION OR PROFESSION (This may be the same as block 4) 07 YEAR SEE INSTRUCTIONS

ORTHOTIST Information in blocks 8-15 represents disclosure for the calendar year listed here: 2024

08 REAL ESTATE INTERESTS involved in transactions with the commonwealth, any of its agencies, or a political subdivision If NONE, check this box

09 CREDITORS TO WHOM IS OWED MORE THAN \$6,500 If NONE, check this box

Name: Address: Interest Rate

10 DIRECT OR INDIRECT SOURCES OF INCOME OF \$1,300 OR MORE, including (but not limited to) all employment If NONE, check this box

Name: Lehigh Valley Health Network Address: 334 Main Street Pottsville City, PA 18542 (OFFICIAL USE ONLY)

11 GIFTS VALUED AT \$250 OR MORE IN THE AGGREGATE If NONE, check this box

Source of Gift Value of Gift

Address of Source of Gift Circumstances (including description) of Gift

12 TRANSPORTATION, LODGING OR HOSPITALITY WHERE ACTUAL EXPENSES EXCEEDED \$650 IN THE AGGREGATE If NONE, check this box

Source (Name and Address) Value

13 OFFICE, DIRECTORSHIP OR EMPLOYMENT IN ANY BUSINESS If NONE, check this box

Business Entity (Name and Address) Position Held (i.e., officer, director, employee, etc.)

Lehigh Valley Health Network Staff ORTHOTIST

14 FINANCIAL INTEREST IN ANY LEGAL ENTITY IN BUSINESS FOR PROFIT If NONE, check this box

Business (Name and Address) Interest Held (i.e., 5%, 10%, etc.)

RECEIVED

15 BUSINESS INTERESTS TRANSFERRED TO IMMEDIATE FAMILY MEMBER If NONE, check this box

Business (Name and Address) Interest Held Relationship Date Transferred

Transferee (Name and Address)

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. §4804 (unsworn falsification to authorities) and the Public Official and Employee Ethics Act, 65 Pa.C.S. §1109(b).

Signature: [Signature] Enter Current Date: 4/24/24

OFFICE OF CITY COUNCIL CLERK

APR 29 2024

THIS FORM IS CONSIDERED DEFICIENT IF ANY BLOCK ABOVE IS NOT COMPLETED. MAKE A COPY FOR YOUR RECORDS. SIGN THE FORM USING CURRENT DATE. DO NOT BACK DATE SIGNATURE.