Agency Report of:
Ceremonial Role Events and Ticket/Pass Distributions

A Public Document

	Date Stamp	California Form **802**
		For Official Use Only

1. Agency Name

Salinas Valley Memorial Healthcare System

Division, Department, or Region *(If Applicable)*

Designated Agency Contact *(Name, Title)*

Lisa Paulo, Clinical Review Specialist

Area Code/Phone Number	E-mail
831-759-1958	lpaulo@svmh.com

☐ **Amendment** *(Must provide explanation in Part 3.)*

Date of Original Filing: _____
(Month, Day, Year)

2. Function or Event Information

Does the agency have a ticket policy?   Yes ☒ No ☐

Event Description __Have a Heart Students Dinner and Aucti__
Provide Title/Explanation

Ticket(s)/Pass(es) provided by agency?   Yes ☐ No ☒

Was ticket distribution made at the behest of agency official?   No ☒ Yes ☐

Face Value of Each Ticket/Pass $ _____150

Date(s) __2__/__20__/__16__   __2__/__20__/__16__

If no: __CSUMB__
Name of Source

If yes: _____
Official's Name (Last, First)

3. Recipients

• Use Section A to identify the agency's department or unit.   • Use Section B to identify an individual.   • Use Section C to identify an outside organization.

A. Name of Agency, Department or Unit	Number of Ticket(s)/ Pass(es)	Describe the public purpose made pursuant to the agency's policy
Administration	3	Per IV.C.2 a/b/c of Gift, Ticket & Honoraria Policy

B. Name of Individual *(Last, First)*	Number of Ticket(s)/ Pass(es)	Identify one of the following:
Orman, Chris	2	Ceremonial Role ☐ Other ☒ Income ☐ *If checking "Ceremonial Role" or "Other" describe below:* Per IV.C.2 d/e of Gift, Ticket & Honoraria Policy
		Ceremonial Role ☐ Other ☐ Income ☐ *If checking "Ceremonial Role" or "Other" describe below:*

C. Name of Outside Organization (include address and description)	Number of Ticket(s)/ Pass(es)	Describe the public purpose made pursuant to the agency's policy

4. Verification

I have read and understand FPPC Regulations 18944.1 and 18942. I have verified that the distribution set forth above, is in accordance with the requirements.

Signature of Agency Head or Designee	Lisa Paulo	Clinical Review Specialist	3/4/16
	Print Name	*Title*	*(Month, Day, Year)*

Comment: _____