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

A Public Document

California Form 802
For Official Use Only

Date Stamp

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 ☐

Face Value of Each Ticket/Pass $ 50

Event Description: Annual Physician of the Year Banquet *(Provide Title/Explanation)*

Date(s) 6 / 17 / 16 — 6 / 17 / 16

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

If no: Monterey County Medical Society *(Name of Source)*

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

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.

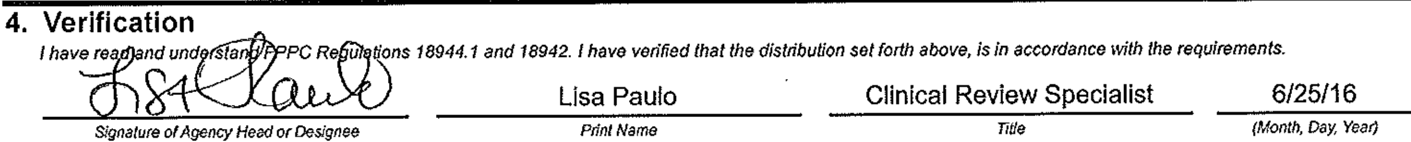
A. Name of Agency, Department or Unit	Number of Ticket(s)/ Pass(es)	Describe the public purpose made pursuant to the agency's policy
Administration	2	Per IV.C.2 a/b/c of Gift, Ticket & Honoraria Policy

B. Name of Individual (Last, First)	Number of Ticket(s)/ Pass(es)	Identify one of the following:
Singh, Rakesh MD	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	Print Name	Title	(Month, Day, Year)
	Lisa Paulo	Clinical Review Specialist	6/25/16

Comment: ________