

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

A Public Document

1. Agency Name Salinas Valley Memorial Healthcare System		Date Stamp	California Form 802 For Official Use Only
Division, Department, or Region <i>(If Applicable)</i>			
Designated Agency Contact <i>(Name, Title)</i> Lisa Paulo, Clinical Review Specialist			
Area Code/Phone Number 831-759-1958	E-mail lpaulo@svmh.com	<input type="checkbox"/> Amendment <i>(Must provide explanation in Part 3.)</i> Date of Original Filing: _____ <small><i>(Month, Day, Year)</i></small>	

2. Function or Event Information

Does the agency have a ticket policy? Yes No Face Value of Each Ticket/Pass \$ _____ 150

Event Description Scramble Date(s) 9 / 11 / 16 9 / 12 / 16
Provide Title/Explanation

Ticket(s)/Pass(es) provided by agency? Yes No If no: Hospice Giving Foundation
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 <small>(Last, First)</small>		
Name of Individual	Number of Ticket(s)/Pass(es)	Identify one of the following:
Peterson, Chris PA	2	Ceremonial Role <input type="checkbox"/> Other <input checked="" type="checkbox"/> Income <input type="checkbox"/> <small><i>If checking "Ceremonial Role" or "Other" describe below:</i></small> Per IV.C.2 d/e of Gift, Ticket & Honoraria Policy
Ramos, David MD	2	Ceremonial Role <input type="checkbox"/> Other <input checked="" type="checkbox"/> Income <input type="checkbox"/> <small><i>If checking "Ceremonial Role" or "Other" describe below:</i></small> Per IV.C.2 d/e of Gift, Ticket & Honoraria Policy
C. Name of Outside Organization <small>(include address and description)</small>	Number of Ticket(s)/Pass(es)	Describe the public purpose made pursuant to the agency's policy

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

 <small><i>Signature of Agency Head or Designee</i></small>	Lisa Paulo <small><i>Print Name</i></small>	Clinical Review Specialist <small><i>Title</i></small>	9/25/16 <small><i>(Month, Day, Year)</i></small>
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Area Code/Phone Number 831-759-1958	E-mail lpaulo@svmh.com	Date of Original Filing: _____ <i>(Month, Day, Year)</i>	

2. Function or Event Information

Does the agency have a ticket policy? Yes No Face Value of Each Ticket/Pass \$ _____ 350

Event Description Scramble Date(s) 9 / 11 / 16 9 / 12 / 16
Provide Title/Explanation

Ticket(s)/Pass(es) provided by agency? Yes No If no: Hospice Giving Foundation
Name of Source

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Administration	4	Per IV.C.2 a/b/c of Gift, Ticket & Honoraria Policy
B. Name of Individual <i>(Last, First)</i>		
		Identify one of the following: Ceremonial Role <input type="checkbox"/> Other <input type="checkbox"/> Income <input type="checkbox"/> <i>If checking "Ceremonial Role" or "Other" describe below:</i>
		Ceremonial Role <input type="checkbox"/> Other <input type="checkbox"/> Income <input type="checkbox"/> <i>If checking "Ceremonial Role" or "Other" describe below:</i>
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 _____ <i>Signature of Agency Head or Designee</i>	Lisa Paulo _____ <i>Print Name</i>	Clinical Review Specialist _____ <i>Title</i>	9/25/16 _____ <i>(Month, Day, Year)</i>
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