

**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 (If Applicable)			
Designated Agency Contact (Name, Title) Lisa Paulo, Clinical Review Specialist		<input type="checkbox"/> Amendment (Must provide explanation in Part 3.) Date of Original Filing: _____ (Month, Day, Year)	
Area Code/Phone Number 831-759-1958	E-mail lpaulo@svmh.com		

2. Function or Event Information

Does the agency have a ticket policy? Yes No Face Value of Each Ticket/Pass \$ _____ 50

Event Description IMPOWER Luncheon Date(s) 5 / 26 / 16 5 / 26 / 16
Provide Title/Explanation


Ticket(s)/Pass(es) provided by agency? Yes No If no: Salinas Rotary Club
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	9	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:
D'Arrigo-Martin, Margaret	2	Ceremonial Role <input type="checkbox"/> Other <input checked="" type="checkbox"/> Income <input type="checkbox"/> <small>If checking "Ceremonial Role" or "Other" describe below:</small> Per IV.C.2 d/e of Gift, Ticket & Honoraria Policy
		Ceremonial Role <input type="checkbox"/> Other <input type="checkbox"/> Income <input type="checkbox"/> <small>If checking "Ceremonial Role" or "Other" describe below:</small>
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.


 _____ Lisa Paulo _____ Clinical Review Specialist _____ 6/12/16
Signature of Agency Head or Designee Print Name Title (Month, Day, Year)