

**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		<input type="checkbox"/> Amendment <i>(Must provide explanation in Part 3.)</i> Date of Original Filing: _____ <i>(Month, Day, Year)</i>	
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 \$ _____ 100

Event Description Pig's, Pinot & More Date(s) 2 / 27 / 16 2 / 27 / 16
Provide Title/Explanation

Ticket(s)/Pass(es) provided by agency? Yes No If no: Salinas Rotary Club of Salinas'
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	6	Per IV.C.2 a/b/c of Gift, Ticket & Honoraria Policy
B. Name of Individual <small>(Last, First)</small>	Number of Ticket(s)/ Pass(es)	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>
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 FRPC Regulations 18944.1 and 18942. I have verified that the distribution set forth above, is in accordance with the requirements.

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