

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

**A Public Document**

<b>1. Agency Name</b> Salinas Valley Memorial Healthcare System		Date Stamp	<b>California Form 802</b> For Official Use Only
Division, Department, or Region (If Applicable)			
Designated Agency Contact (Name, Title) Lisa Paulo, Clinical Review Specialist			
Area Code/Phone Number 831-759-1958	E-mail lpaulo@svmh.com	<input type="checkbox"/> 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 Man & Woman of the Year Grand Final  
*Provide Title/Explanation*

Face Value of Each Ticket/Pass \$ \_\_\_\_\_ 125

Date(s) 5 / 14 / 16 5 / 14 / 16

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

If no: Leukemia & Lymphoma Society  
*Name of Source*

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

If yes: \_\_\_\_\_  
*Official's Name (Last, First)*

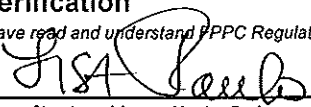
**3. Recipients**

• 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	8	Per IV.C.2 a/b/c of Gift, Ticket & Honoraria Policy
<b>B. Name of Individual (Last, First)</b>		
	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>
<b>C. Name of Outside Organization (include address and description)</b>		
	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 5/21/16  
*Signature of Agency Head or Designee* *Print Name* *Title* *(Month, Day, Year)*