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

A Public Document

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

Date Stamp

California Form 802

For Official Use Only

☐ **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 $ _____ 55

Event Description ___95th Annual Awards Luncheon___
Provide Title/Explanation

Date(s) __2_/_25_/_16_   __2_/_25_/_16_

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

If no: ___Salinas Valley Chamber of Commerce___
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	7	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:
		Ceremonial Role ☐ Other ☐ Income ☐ *If checking "Ceremonial Role" or "Other" describe below:*
		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.

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

Comment: _____