**Hospital & VAVS Activity Report**

**Please mail/email this report within 30 days of any activity to**

**Barbara Wiener 201 6th St. N. Brigantine NJ 08203 barb.wiener@yahoo.com**

**Auxiliary President**_____**Date**_____

**Auxiliary Name & Number**_____

**Auxiliary Chairman**_____**Phone Number**_____

**If the Event was held by a Hospital Representative and not an Auxiliary**

**Hospital Rep Name**_____**Date**_____

***LIST THE NAMES OF ANY VOLUNTEERS ON THE BACK OF THE SHEET***

**Section 1 – Items or Money Donated to Hospital**

Name of Hospital the donation was made_____

Date of Donation_____Approx Dollar Amt._____

**Section 2 – Hospital Party, Non-sponsored Hospital parties or any other activity**

Name of Hospital/Facility the Party was held_____

Type of Activity_____

**NUMBER** of **VOLUNTEERS**_____Number of Hours_____

Number of Students_____Number of Hours_____

**Section 3 – Reporting Regularly Scheduled Volunteers**

Name of Volunteer_____

Name of Hospital/Facility_____

Total Hours for this Report_____Dates Volunteered_____

Does this Volunteer qualify for a Hospital Service Pin----Yes_____No_____

Total Number of Projects for this Report_____

Total Number of **Members** that participated_____

Hours worked this report_____Total Miles Traveled_____ Total dollar value_____

**For non-sponsored hospitals, please provide proof for credit**