

DO NOT INCLUDE THIS DOCUMENT IN A PATIENT'S MEDICAL RECORD

SPONSORED ACTIVITY DATA

VOLUNTEERS: *PLEASE* print the required information below. It is imperative that the necessary information be complete so that we may accurately recognize your organization's contribution. If you have any questions, please feel free to contact the secretary Monday through Friday, 9:00 a.m. – 5:30 p.m.

ACTIVITY DATE: _____ ORGANIZATION: _____

YOUR NAME: _____ DAYTIME PHONE: _____

YOUR ADDRESS: _____
STREET CITY STATE ZIP

SPONSORED ACTIVITY AND AREA: _____

PLEASE ENTER THE ~TOTAL~ ESTIMATED DOLLAR AMOUNT FOR EACH RELEVANT CATEGORY. (IF ANY CATEGORY BELOW DOES NOT PERTAIN TO YOUR ACTIVITY, PLEASE LEAVE BLANK.)

PRIZES: \$ _____ REFRESHMENTS: \$ _____ COMMUNITY FEES: \$ _____

By signing below, these Occasional Volunteers agree, for an indefinite period, with the following statement: I hereby waive all claims to monetary benefits for services rendered as a volunteer worker on a "without compassion basis." I understand that this waiver applies only to compensation for other services or benefits of which I may be entitled. (NOTE: VA has been entered into this agreement by the authority of 38 USC, Section 513. This agreement may be canceled by either party upon written notification.)

PRINT NAME	SIGNATURE	# OF HOURS

(AMIS _____ TYL _____) Therapist _____ EXT: _____