HOSPITAL AND VAVS REPORT
MAIL REPORT WITHIN 30 DAYS OF ACTIVITY TO:

ELIZABETII A. KITSON
399 LINCOLN AVENUE CLIFFSIDE PARK, NJ 07010
201-282-4204
Email: kitsonbetty@gmail.com

Auxiliary_____ District #_____Date_____

Auxiliary Hospital Chairman _____ Phone #_____

Auxiliary President _____ Phone #_____

Section. Items or Money donated to Hospital:
Name of Hospital donation was made to_____

Date of donation _____ Dollar amount of donation _____

Number of Volunteers _____ Number of Hours _____

Number of Students _____ Number of Hours _____

Section2. Hospital Party, Off Station or other Activity:

Name of Facility where activity was held _____

Type of Activity_____

Number of Volunteers_____ Number of Hours_____

Number of Students Attending,_____ Number of Hours_____

Total Cost to Student (Item & Mileage @ .12 per mile) _____

Section3. Reporting Regularly Scheduled Volunteers:

Name of Volunteer_____

Facility_____

Hours this report_____ Dates from _____ to _____

Does this Volunteer qualify for a Hospital Service Pin? Yes_____No_____

Total number of Projects this report_____ Total number of hours worked_____

Number of members participating _____ Total number of miles_____

Total value or Dollars spent. _____

No Proof is needed for activities at 5 sponsored facilities.
Proof is needed for all other hospitals to receive credit**
Please List Names of Volunteers on Back of Sheet*