

**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		<input type="checkbox"/> Amendment (Must provide explanation in Part 3.) Date of Original Filing: _____ (Month, Day, Year)	
Area Code/Phone Number 831-759-1958	E-mail lpaulo@svmh.com		

**2. Function or Event Information**

Does the agency have a ticket policy?    Yes     No     Face Value of Each Ticket/Pass \$ \_\_\_\_\_ 160

Event Description Airshow    Date(s) 10 / 23 / 16    10 / 25 / 16  
Provide Title/Explanation


Ticket(s)/Pass(es) provided by agency?    Yes     No     If no: California International Airshow  
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	4	Per IV.C.2 a/b/c of Gift, Ticket & Honoraria Policy
<b>B. Name of Individual (Last, First)</b>		
		<b>Identify one of the following:</b>
D'Arrigo-Martin, Margaret	3	Ceremonial Role <input type="checkbox"/> Other <input checked="" type="checkbox"/> Income <input type="checkbox"/> If checking "Ceremonial Role" or "Other" describe below: Per IV.C.2 d/e of Gift, Ticket & Honoraria Policy
Garcia, Rafael	3	Ceremonial Role <input type="checkbox"/> Other <input checked="" type="checkbox"/> Income <input type="checkbox"/> If checking "Ceremonial Role" or "Other" describe below: Per IV.C.2 d/e of Gift, Ticket & Honoraria Policy
<b>C. Name of Outside Organization (include address and description)</b>		
		<b>Describe the public purpose made pursuant to the agency's policy</b>

**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.

 <small>Signature of Agency Head or Designee</small>	Lisa Paulo <small>Print Name</small>	Clinical Review Specialist <small>Title</small>	11/2/16 <small>(Month, Day, Year)</small>
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Agency Report of:  
 Ceremonial Role Events and Ticket/Pass Distributions  
 Continuation Sheet

Agency Name  
 Salinas Valley Memorial Healthcare System

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
B. Name of Individual <i>(Last, First)</i>	Number of Ticket(s)/ Pass(es)	Identify one of the following:
Rey, Victor	2	Ceremonial Role <input type="checkbox"/> Other <input checked="" type="checkbox"/> Income <input type="checkbox"/> <i>If checking "Ceremonial Role" or "Other" describe below:</i> Per IV.C.2 d/e of Gift, Ticket & Honoraria Policy
		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>
		Ceremonial Role <input type="checkbox"/> Other <input type="checkbox"/> Income <input type="checkbox"/> <i>If checking "Ceremonial Role" or "Other" describe below:</i>
C. Name of Outside Organization <i>(include address and description)</i>	Number of Ticket(s)/ Pass(es)	Describe the public purpose made pursuant to the agency's policy

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<b>1. Agency Name</b> Salinas Valley Memorial Healthcare System Division, Department, or Region <i>(If Applicable)</i>  Designated Agency Contact <i>(Name, Title)</i> Lisa Paulo, Clinical Review Specialist Area Code/Phone Number   E-mail 831-759-1958   lpaulo@svmh.com	Date Stamp	<b>California Form 802</b> For Official Use Only
<input type="checkbox"/> Amendment <i>(Must provide explanation in Part 3.)</i>		Date of Original Filing: _____ <i>(Month, Day, Year)</i>

**2. Function or Event Information**

Does the agency have a ticket policy?    Yes     No     Face Value of Each Ticket/Pass \$ \_\_\_\_\_ 30

Event Description Airshow    Date(s) 10 / 23 / 16    10 / 25 / 16  
*Provide Title/Explanation*

Ticket(s)/Pass(es) provided by agency?    Yes     No     If no: California International Airshow  
*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	4	Per IV.C.2 a/b/c of Gift, Ticket & Honoraria Policy
<b>B. Name of Individual <small>(Last, First)</small></b>		
<b>Identify one of the following:</b>		
Gil, Carmen	5	Ceremonial Role <input type="checkbox"/> Other <input checked="" type="checkbox"/> Income <input type="checkbox"/> If checking "Ceremonial Role" or "Other" describe below: Per IV.C.2 d/e of Gift, Ticket & Honoraria Policy
		Ceremonial Role <input type="checkbox"/> Other <input type="checkbox"/> Income <input type="checkbox"/> If checking "Ceremonial Role" or "Other" describe below:
<b>C. Name of Outside Organization <small>(include address and description)</small></b>		
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.*

 Signature of Agency Head or Designee	Lisa Paulo Print Name	Clinical Review Specialist Title	11/2/16 (Month, Day, Year)
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