VAVS REPRESENTATIVE HOSPITAL FUND REPORT

Funds Allocated for VAVS Hospital Program from the Department Treasury

Monthly Report

You will need three (3) copies of this report.

Send: One copy to Dept. Treasurer and One copy to Dept. Hospital Chairman, **with receipts**. File one copy.

Name of Hospital _____

Representative _____

Address _____

Date _____ Month_____ Patient Count #_____

Number required

Monthly allowance from Department $_____

Special funds received from Department $_____

Total $_____

Expenditures $_____

Balance on hand end of month $_____

	Name	**# of visits**	**Hours**
Representative			
Deputy			
Deputy			
Deputy			

Items purchased:

_____

_____

_____

_____

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ALL FUNDS SHALL GO THROUGH THE DEPARTMENT TREASURER
DO NOT KEEP ANY SEPARATE ACCOUNTS FOR HOSPITAL FUNDS.
ONLY THE DEPARTMENT TREASURER IS BONDED FOR THESE FUNDS.
SEE BYLAWS SECTION 813C.