HOSPITAL REPORT

COVERING THE PERIOD OF APRIL 1, 2024 THROUGH NOVEMBER 30, 2024

Must be RECEIVED by the Dept. Chairman no later than 12/31/2024

Mail to Mary Williams, 20 John E. Smith Dr., Tewksbury, MA 01876

maryw49@gmail.com Assistance: 978-851-6064

Auxiliary No. _____ Location _____ District No. _____ Division _____

1. Number of members attending the Hospital/Veterans & Family Support Workshop _____
2. Number of members volunteering in VA and non-VA facilities. _____ No. Hours_____

(Auxiliary member to be counted one time per year)

3. Number of non-member Sponsored Volunteers: Adults_____ Youth _____

   Total Hours _____
4. Did your Auxiliary sponsor a party/function for any facility, both VA and non-VA? _____
5. Did your Auxiliary donate items to a medical center/soldiers home, hospital or nursing home? _____ Explain_____

6. Did your Auxiliary promote, participate in or host any activity listed (alone or with Post): Honors Escort / National Salute to Veterans Patients-Valentines for Veterans Veterans Health Care (VHA) / Women Veterans Health Care Program

Explain_____

7. Donation to the Department Hospital Fund (Hospital Pledge) $_____
8. Total amount spent on all Hospital projects: $_____

Attach extra sheets for additional information if needed.

Contact Name _____

Phone _____ Email _____