



American Legion Auxiliary
Department of California

GIFT SHOP/PATIENT REMEMBRANCE EXPENSE SHEET

Check Number _____

Check Amount \$ _____

This form must be filled out, signed and returned to the Department VA&R Chairman with copy of receipts prior to Mid-Year Meeting. Copy of report and original receipts are to be sent to the Department Office.

Patient Remembrance Report		
# of Patients Served	Items	Amount Spent on Items
		\$
		\$
		\$
		\$
		\$
Gift Shop Report		
# of Patients Served	Items	Amount Spent on Items
		\$
		\$
		\$
		\$
		\$
		\$

Signature of Hospital Representative

Name of Medical Center

Home Address _____

E-mail: _____ Phone # _____