POST HOSPITAL REPORT

DATE: _____ **PERIOD - MONTH ENDING** _____

DEPA RTMENT: WASHINGTON **DISTRICT** **POST NO.** ___

LIST PROJECTS BELOW

DATE	DESCRIPTION	NUMBER OF PATIENTS	NUMBER OF PEOPLE PARTICIPATING	TOTAL HOURS	TOTAL MILES	DONATION OF SERVICES
		0	0	0	0	$0.00

NOTE: *If description block is not adequate, put additional information on back of form*

SIGNED _____

TITLE: _____

District Surgeon/Commander ____ _____

FORWARD THIS REPORT TO:
DEPARTMENT HEADQUARTERS
5213 Pacific Highway East
Fife, Washington 98424

TOTAL HOURS	**X**	**$16.10**	**$ -**
TOTAL MILES	**X**	**$0.14**	**$ -**
TOTAL DONATIONS OR SERVICES			
BLOOD DONATIONS-Pints		0	
NUMBER OF PINTS	**X**	**$69.00**	**$ -**
CARDS & FLOWERS			
TOTAL VALUE OF REPORT			**$ -**