

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

<b>1. Agency Name</b> San Gorgonio Memorial Hospital		Date Stamp	<b>California Form 801</b> For Official Use Only
Division, Department, or Region (if applicable) n/a			
Street Address 600 N. Highland Springs Ave., Banning, CA 92220			
Area Code/Phone Number (951) 769-2160	Email bduffy@sgmh.org	<input type="checkbox"/> Amendment (explain in comment section)	
Agency Contact (name and title) Bobbi Duffy, Executive Assistant		Date of Original Filing: _____ (month, day, year)	

**2. Donor Name and Address**

Individual \_\_\_\_\_  Other California Hospital Association

\_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Name \_\_\_\_\_

1215 K Street, Suite 800 Sacramento CA 95814

Address City State Zip Code

Hospital association \_\_\_\_\_

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.

—————> If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

n/a	\$ 0.00	n/a	\$ 0.00
_____ Name	_____ Amount	_____ Name	_____ Amount

**3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)**

**3.1 (a) Travel Payment** Sacramento, CA September 19-21, 2016

\_\_\_\_\_ Location of Travel \_\_\_\_\_ Dates (month, day, year)

n/a \_\_\_\_\_  Rail  Air  Bus  Auto  Other Hyatt Regency

\_\_\_\_\_ Transportation Provider \_\_\_\_\_ Check Applicable Boxes \_\_\_\_\_ Name of Lodging Facility

\$ 415.60	\$ 0.00	\$ 0.00	\$ 1,590.00	\$ 2,005.60
_____ Lodging Expenses	_____ Meal Expenses	_____ Transportation Expenses	_____ Other Expenses	_____ Total Expenses

**3.1 (b) Payment(s) not related to travel:** \_\_\_\_\_ n/a \$ 0.00

\_\_\_\_\_ Dates (month, day, year) \_\_\_\_\_ Total Expenses

**3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.**

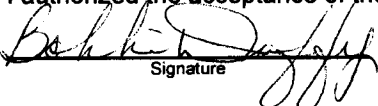
Attendance and featured speakers at California Hospital Association's "Utilizing Law Enforcement in Promoting a Healthcare Facility's Workplace Violence Prevention Program & to Build Resilience".

**3.3. Identify the officials who used the payment in Section 3.1 (See instructions)**

<u>Merrick</u>	<u>Janna</u>	<u>Director</u>	<u>Emergency Preparedness</u>
_____ Last Name	_____ First Name	_____ Position/Title	_____ Department/Division
<u>Brown</u>	<u>Patricia</u>	<u>Chief Nursing Officer</u>	<u>Nursing Administration</u>
_____ Last Name	_____ First Name	_____ Position/Title	_____ Department/Division

**4. Verification**

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

 Bobbi Duffy Executive Assistant 09/21/16

\_\_\_\_\_ Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Title \_\_\_\_\_ (month, day, year)

Comment: n/a

(Use this space or an attachment for any additional information)

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