| VA Medical Center (552) | MEDICAL WORKSHEET |
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DO NOT INCLUDE THIS DOCUMENT IN A PATIENT'S MEDICAL RECORD

# SPONSORED ACTIVITY DATA

**VOLUNTEERS:** *PLEASE* print the required information below. It is imperative that the necessary information be complete so that we may accurately recognize your organization's contribution. If you have any questions, please feel free to contact the secretary Monday through Friday, 9:00 a.m. – 5:30 p.m.

ACTIVITY DATE: ________________ ORGANIZATION: ____________________________________

YOUR NAME: __________________________________ DAYTIME PHONE: ____________________

YOUR ADDRESS: ____________________________________________________________________
*STREET* *CITY* *STATE* *ZIP*

SPONSORED ACTIVITY AND AREA: ______________________________________________________

***PLEASE ENTER THE ~TOTAL~ ESTIMATED DOLLAR AMOUNT FOR EACH RELEVANT CATEGORY. (IF ANY CATEGORY BELOW DOES NOT PERTAIN TO YOUR ACTIVITY, PLEASE LEAVE BLANK.)***

PRIZES: $__________ REFRESHMENTS: $___________ COMMUNITY FEES: $_____________

*By signing below, these Occasional Volunteers agree, for an indefinite period, with the following statement:*
*I hereby waive all claims to monetary benefits for services rendered as a volunteer worker on a "without compassion basis." I understand that this waiver applies only to compensation for other services or benefits of which I may be entitled. (NOTE: VA has been entered into this agreement by the authority of 38 USC, Section 513. This agreement may be canceled by either party upon written notification.)*

| PRINT NAME | *SIGNATURE* | # OF HOURS |
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(AMIS ______ TYL ______) Therapist________________________ EXT: ________