



Hospital Program



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Name: _____

Phone: _____

Address: _____

Email: _____

District: _____

Date of Report: _____

Auxiliary: _____

Auxiliary Members who volunteer at a VA and/or non VA Medical Facility may be counted **ONE TIME PER YEAR**

Volunteering

Did any Auxiliary members volunteer at a VA or non VA Medical Facility? Yes ____ No ____

Number of members: _____ Number of hours volunteered: _____

Were there any youth or family members who volunteered? Yes ____ No ____

Number of volunteers: _____ Number of hours volunteered: _____

Did your Auxiliary participate in any of the following:

Honors Escort Yes ____ No ____ Number of volunteers: _____ Number of hours volunteered: _____

Valentines for Veterans Yes ____ No ____ Number of volunteers: ____ Number of hours volunteered: ____

Women Veterans Health Care Yes ____ No ____ Number of volunteers: ____ Number of hours volunteered: ____

Other _____

Number of volunteers: _____ Number of hours volunteered: _____

DONATIONS

Has your Auxiliary:

Donated to the Department VA Medical Fund? Yes ____ No ____ Amount _____

Donated goods/money to any VA or non VA Medical Facility? Yes ____ No ____ Amount _____

Is your Auxiliary promoting the *Hospital QR Code*? Yes ____ No ____

Comments: _____
