POST HOSPITAL REPORT

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

DEPARTMENT: **WASHINGTON** **DISTRICT** _____ **POST NO.** _____

LIST PROJECTS BELOW

DATE	DESCRIPTION	NUMBER OF PATIENTS	NUMBER OF PEOPLE PARTICIPATING	TOTAL HOURS	TOTAL MILES	Donations and Services (Dollar amount)
	Totals	**0**	**0**	**0**	**0**	**$0.00**

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

SIGNED _____

TITLE: surgeon

PHONE # _____

E-MAIL: _____

FORWARD THIS REPORT TO:
VFW, Department of Washington
5213 Pacific Highway East
Fife, WA 98424 or e-mail to:
VFW State of WA Surgeon
Ted Streete mailto:sgtmajted@msn.com

TOTAL HOURS **0** **$** -

TOTAL MILES **0** **$** -

TOTAL DONATIONS OR SERVICES **$0.00**

BLOOD DONATIONS NUMBER OF PINTS _____ **$0.00**

TOTAL VALUE OF REPORT **$** -

Revised June 2008