Hospital Program

2025-2026 Report Form

Cynthia Davis, PDP Dept. Chairman

3532 Carriage Hill Circle, Apt. T2

Randallstown, MD 21133

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Auxiliary _____ District _____ Chairman_____

Reporting Period: From_____ To_____

This month - Hours_____ Projects Cost $_____ Mileage_____ Volunteers #_____

Number of Auxiliary members that volunteered at any VA and/or non-VA medical facility (Auxiliary member to be counted one time only per year) : Number of Volunteers #_____

Total number of hours that Auxiliary members volunteered and any VA and/or non-VA medical facility. Hours # _____

Total number of hours that Sponsored Volunteers and/or students volunteered under the your auxiliary sponsorship and/or supervision of your auxiliary. Hours #_____

Did your Auxiliary host or co-host any activity with their VFW Post at any VA and/or non-VA medical facility?

Honors Escort	Yes ☐	No ☐
National Salute to Veteran Patients- Valentines for Veterans	Yes ☐	No ☐
Veterans Health Care (VHA)	Yes ☐	No ☐
Women Veterans Health Care Program	Yes ☐	No ☐
Other (Bingo, pizza party, etc) Please describe below	Yes ☐	No ☐

Did your auxiliary recognize hospital volunteers? #_____ of Hospital Appreciation Certificates

#_____ of Hospital Volunteer Pin Presented

Hospital Treat donation amount $_____ Hospital Fund donation amount $_____

Other projects or activities (use additional sheet if necessary):