



**DEPARTMENT OF MARYLAND
Veterans of Foreign Wars of the
United States War Memorial
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*** HOSPITAL REPORT FORM ***

Date: _____ Period: _____ Month ending: _____

Department of Maryland District No. _____ Post No. _____

List of projects: Forward a copy of this report to the Department, fill in all columns where applicable.

DATE	DESCRIPTION	NUMBER PATIENTS BENEFITTED	NO PERSONS PARTICIPATING PER VISIT	TOTAL HOURS	TOTAL MILES	DONATIONS OR SERVICES
TOTALS						
NUMBER OF PATIENTS BENEFITTED						
NUMBER OF PERSONS PARTICIPATED						
TOTAL HOURS ()X \$0.00						
TOTAL MILES ()X \$0.14						
TOTAL DONATIONS OR SERVICES						
BLOOD DONATIONS - NUMBER OF PINTS ()X \$69.00						
CARDS AND /OR FLOWERS						
TOTAL VALUE OF THIS REPORT						

Name: _____ Title: _____

Send Report to Department Headquarters