Department of NY VFW Auxiliary

Hospital

Year-End Report

Must Reach Department Chairman BEFORE April 1, 2025

Auxiliary Name: _____ #_____

District #_____ Auxiliary Chairman: _____

1. **How many Auxiliary members volunteer at any VA and/or non-VA medical facility? (Auxiliary member to be counted ONE time only per year) _____**

2. **Total number of hours that Auxiliary members volunteered at any VA or non-VA medical facility. _____**

3. **Total number of hours of SPONSORED Non-Members and/or students who volunteered under the VFW Auxiliary sponsorship and/or supervision at any VA or non-VA medical facility. _____**

4. **Did your Auxiliary host or co-host any activity with your Post at any VA or non-VA medical facility? Y / N**

5. **Total dollar amount spent on all Hospital Program related items and/or projects $_____**

Auxiliary Chairman signature_____

Chairman Phone number: _____ Email_____