Eastern Colorado Health Care System
1700 N Wheeling Street G1-306 Aurora, CO 80045
VHAECHVolSvcs@va.gov 720.723.3864

DONATIONS / ACTIVITIES

PRINT CLEARLY!

Date:

*Select if Donation if from an **Organization/Group/Company** **OR** **Individual***

☐ ORGANIZATION Name: | ***or*** ☐ INDIVIDUAL Name:

Point of Contact:

Local Chapter/Unit/Team:

If you are affiliated with a Veterans Service Organization or group, list it below (as an individual, you are making the donation, but the Organization will also receive "credit"):

All Donors:

Address: _____

City/State/Zip: _____

Phone: E-mail:

ITEM(S) *Check the appropriate box below and/or give a brief description:*

☐ Other: _____

(including gift cards and canteen books) _____

ESTIMATED TOTAL VALUE of ITEMS: $

ACTIVITIES *Indicate the type of activity provided and/or give a brief description:*

☐ Bingo ☐ Food/Refreshments ☐ Entertainment

☐ Other: _____

_____

_____

Campus/Area/Unit of Activity: _____

Date & Time of Activity: _____

ESTIMATED TOTAL VALUE of ACTIVITY $

MONETARY DONATIONS *will be used as authorized by law or in ways that benefit VA patients while receiving care from the VA (VHA Directive 4721). If you wish to restrict your donation for a specific program or service, please indicate so below. The Voluntary Service office may contact you if additional information is required or if the specific restriction cannot be honored.*

Checks must be completely filled out, with an address written or printed on the top.

Restrictions or Earmarks: _____

_____

(e.g., cash, check) **TOTAL MONETARY DONATION: $**

CDCE OFFICE USE

Computer Input Date

Staff Initials

ID#

File Date

VA Staff Receiving Donation (if other than CDCE): _____

Phone number: _____

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VOLUNTEER SIGN-IN

By signing below, these volunteers agree, for an indefinite period, with the following statement: "I hereby waive all claims to monetary benefits for services rendered as a volunteer worker on a "without compensation basis". I understand that this waiver applies only to compensation for specific services rendered in the Voluntary Service Program and has no relation to any compensation for other services or benefits to which I may be entitled. (VA has entered into this agreement by the authority of 38 U.S.C., Section 513. Either party, upon written notification, may cancel this agreement.)

Only Sign-In on this form if you did NOT log these hours electronically or on a kiosk.

	PRINT NAME	HOURS	**Registered Volunteers:** *Assignment / Organization*
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			
(7)			
(8)			
(9)			
(10)			
(11)			
(12)			
(13)			
(14)			
(15)			
(16)			
(17)			
(18)			
(19)			
(20)			

VA Staff certifying hours (if other than CDCE): _____

Phone number: _____

Return form to CDCE: Fax: 813-903-4865 VHATAMCDCE@va.gov