ayment to Agency R	eport	A Public Documer	nt	PAYMENT TO AGENCY REPO
1. Agency Name San Gorgonio Memorial Hospital Division, Department, or Region (if applicable) n/a			Date Stamp	California O O
				Form For Official Use Only
Street Address	TENNEN AND AND AND AND AND AND AND AND AND AN		-	
600 N. Highland Springs Av	venue, Banning, CA	92220		
Area Code/Phone Number	Email		1	
(951) 769-2160	bduffy@sgmh.org		Amendment (explain in comment section)	
Agency Contact (name and title)			Date of Original F	iling:
Bobbi Duffy, Executive Assi	istant			(month, day, year)
Donor Name and Addre				
			Envision Physic	ian Services (EmCare)
☐ Individual ————— ☑ Othe		Name		
3916 State Street, Suite 30	0	Santa Barbara	C	A 93105
Address		City	Sta	te Zip Code
Supply Hospitalists and Em	ergency Departmer	nt physicians		
If "Other" is marked, describe the entity'	s business activity (if busine	ess) or its nature and interests.		
> If applicable in	dentify the name of or	ach course and the amount(s)	manaissad buddha dan	and familia in a second
	dentity the name of ea	ach source and the amount(s)	received by the done	or for this payment:
n/a Name	\$	Amount n/a		\$
			Name	Amount
Payment Information (C		and the second s		
3.1 (a) Travel Payment	Las Vegas, Ne	vada	Ap	oril 18 - 20, 2017
	Lo	ocation of Travel		Dates (month, day, year)
n/a		☐ Air ☐ Bus ☐ Au	uto □ Other W	ynn Las Vegas
Transportation Provider		Check Applicable Boxes		Name of Lodging Facility
\$\$	1,470.00 Meal Expenses	\$ Transportation Expenses	0.00	_e 2,904.00
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	\$Total Expenses
3.1 (b) Payment(s) not related to travel: Output Dates (n/a	\$ 0.00	
		Dates (month		Total Expenses
3.2. Payment Description.	Provide a specifi	c description of the payr	nent and its agen	cv purpose and use
,				o, pa. poco aa acc.
			12	
EmCare Annual Leade	rship Conferenc	e - paying hotel and m	ieals.	
3.3. Identify the officials v	vho used the paym	nent in Section 3.1 (See inst	tructions)	
Brown	Patricia	Chief Nurs	sing Officer	Administration
Last Name	First Name		osition/Title	Department/Division
Edot Hairio	riotricanic	,	Salion/ Title	Department/Division
Ritarita	Trisha	Director		Emergency Department
Last Name	First Name	P P	osition/Title	Department/Division
Verification				
I authorized the acceptance	of the reported nov	ment(s) as in compliance :	with EDDC recorded	one
admonzed the acceptance	1		ŭ	
Dokkertes	Bobbi Duffy		cutive Assistant	04/24/17
Signature)/ `	Print Name	Title	(month, day, year
Comment: Add'l attendee:	Brady, Angela	Charge Nurse	Emergency Depar	tment
(Use this space or an attachment for		-	_ , ,	