

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name
San Gorgonio Memorial Hospital
Division, Department, or Region (if applicable)
n/a
Street Address
600 N. Highland Springs Avenue, Banning, CA 92220
Area Code/Phone Number
(951) 769-2160
Email
bduffy@sgmh.org
Agency Contact (name and title)
Bobbi Duffy, Executive Assistant
Date Stamp
California 801 Form
For Official Use Only
Amendment (explain in comment section)
Date of Original Filing: (month, day, year)

2. Donor Name and Address
Individual Other
Envision Physician Services (EmCare)
3916 State Street, Suite 300 Santa Barbara CA 93105
Supply Hospitalists and Emergency Department physicians

If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.
If applicable, identify the name of each source and the amount(s) received by the donor for this payment:
n/a

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)
3.1 (a) Travel Payment
Las Vegas, Nevada April 18 - 20, 2017
Wynn Las Vegas
Lodging Expenses: \$1,434.00 Meal Expenses: \$1,470.00 Transportation Expenses: \$0.00 Other Expenses: \$0.00 Total Expenses: \$2,904.00

3.1 (b) Payment(s) not related to travel:
n/a \$ 0.00
Dates (month, day, year) Total Expenses

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.
EmCare Annual Leadership Conference - paying hotel and meals.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)
Brown Patricia Chief Nursing Officer Administration
Ritarita Trisha Director Emergency Department

4. Verification
I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.
Signature: Bobbi Duffy Print Name: Bobbi Duffy Title: Executive Assistant Date: 04/24/17
Comment: Add'l attendee: Brady, Angela Charge Nurse Emergency Department

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