# COMMUNITY BENEFIT REPORT

NAME OF EVENT/ACTIVITY:                          DATE:

NUMBER OF PERSONS SERVED:

DESCRIPTION/PURPOSE OF EVENT/ACTIVITY:

## NON-STAFF DIRECT EXPENSES

**Brochures, mileage, equipment**

SUPPLIES: (includes brochures, copies etc.)

Number of Color copies:

MILEAGE:

 (Indicate how many miles to and from event)

FOOD:                          _____

Other Expenses:                _____

Include: Brochures, Flyers, Forms, supplies taken to distribute at the Event/Activity. Indicate # of brochures, copies to distribute.

## STAFFING

**Indicate the classification of staff, who attended the event and number of hours attended and planning.**

|  | Hours at Event | Planning Hours |
|---|---|---|
| VP: | _____ | _____ |
| Director: | _____ | _____ |
| Dept. Mgr. | _____ | _____ |
| Physician: | _____ | _____ |
| Mid-Level Provider | _____ | _____ |
| Nurses RN | _____ | _____ |
| LPN/Med Asst. | _____ | _____ |
| Staff (OT, PT, RT, RX) | _____ | _____ |
| Coordinator | _____ | _____ |
| Clerical | _____ | _____ |
| Volunteers | _____ | _____ |

## TYPE OF COMMUNITY EVENT

☐ Seminar                              ☐ Screening

☐ Event/Meeting                        ☐ Clinic

☐ Health Fair                          ☐ Speaking engagement

☐ TV/Radio                             ☐ Other_____

☐ Newsletter

## TARGET GROUPS

☐ Person with Disabilities

☐ Uninsured

☐ Underinsured

☐ Racial, Cultural & Ethnic Minorities

☐ Maternal/Child

☐ Seniors

## TARGET HEALTH PRIORITIES

☐ Obesity

☐ Mental Health

☐ Tobacco Cessation

☐ Substance Abuse

## NOTES / COMMENTS

NAME:                                          DATE:

        (Please Print)

Department:                                    Contact Number: