

American Legion Auxiliary
Department of Illinois
Hospital Services/ Service to Veterans

Name _____
Address _____

YTD hrs	SV	0
	Hos.	
Cumulative hrs	SV	0
	Hos.	

Facility:

Volunteer Workers Schedule of Hours

___ Service to Veterans

___ Hospital Hours

Hospital
Service to Veterans

Work Done	Date	Time in	Time Out	Total Hrs.

Cinda Held

Department Chairman

Date