

**Agency Report of:
Ceremonial Role Events and Ticket/Pass Distributions**

A Public Document

1. Agency Name Alameda County		Date Stamp	California Form 802
Division, Department, or Region (If Applicable) Board of Supervisors			For Official Use Only
Designated Agency Contact (Name, Title) Michelle Dianda		<input type="checkbox"/> Amendment (Must provide explanation in Part 3.) Date of Original Filing: _____ (Month, Day, Year)	
Area Code/Phone Number (510) 272-6692	E-mail michelle.dianda@acgov.org		

2. Function or Event Information

Does the agency have a ticket policy? Yes No Face Value of Each Ticket/Pass \$ _____ 250.00

Event Description Warriors vs. Sacramento Kings Date(s) 12 / 22 / 14 _____ / _____ / _____
Provide Title/Explanation

Ticket(s)/Pass(es) provided by agency? Yes No If no: Golden State Warriors
Name of Source

Was ticket distribution made at the behest of agency official? No Yes If yes: Valle, Richard- Supervisor District 2
Official's Name (Last, First)

3. Recipients
 * Use Section A to identify the agency's department or unit. * Use Section B to identify an individual. * Use Section C to identify an outside organization.

A. Name of Agency, Department or Unit	Number of Ticket(s)/ Pass(es)	Describe the public purpose made pursuant to the agency's policy
B. Name of Individual <small>(Last, First)</small>	Number of Ticket(s)/ Pass(es)	Identify one of the following:
		Ceremonial Role <input type="checkbox"/> Other <input type="checkbox"/> Income <input type="checkbox"/> <small>If checking "Ceremonial Role" or "Other" describe below.</small>
		Ceremonial Role <input type="checkbox"/> Other <input type="checkbox"/> Income <input type="checkbox"/> <small>If checking "Ceremonial Role" or "Other" describe below.</small>
C. Name of Outside Organization <small>(include address and description)</small>	Number of Ticket(s)/ Pass(es)	Describe the public purpose made pursuant to the agency's policy
St. Rose Hospital Foundation 27200 Calaroga Ave. Hayward, CA 94545	4	To reward a non-profit organization for its contributions to the community.
Raises funds to continue hospital mission of providing quality health care		

4. (d)(5)

944.1 and 18942. I have verified that the distribution set forth above, is in accordance with the requirements.

_____ Michelle Dianda <small>Print Name</small>	_____ Supervisor's Aide <small>Title</small>
	_____ 11/10/14 <small>(Month, Day, Year)</small>

Comment: Includes 1 parking pass at the value of \$30