DEPARTMENT OF MARYLAND
VETERANS OF FOREIGN WARS OF THE UNITED STATES

Tiffany Daniel, State Chaplain
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Waldorf, MD 20602
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POST/DISTRICT CHAPLAIN REPORT

PLEASE PRINT OR TYPE ALL INFORMATION

District Number:____________ Post Number:_________________ Date:_____________________
Chaplain's name:____
Address:____
City:_______________________________ State:________________ Zip Code:_______________
Phone Number:____

DECEASED COMRADES

Name of Deceased:___________________________________ Date Deceased________________
Address:____
City:_______________________________ State:________________ Zip Code:_______________
Do you request the State Chaplain to send a sympathy card to the family of the deceased?
☐ Yes ☐ No
Name and Address of next of kin (for card only)____
____
Did you participate in the funeral service? ☐ Yes ☐ No

Name of Deceased:___________________________________ Date Deceased________________
Address:____
City:_______________________________ State:________________ Zip Code:_______________
Do you request the State Chaplain to send a sympathy card to the family of the deceased?
☐ Yes ☐ No
Name and Address of next of kin (for card only)____
____
Did you participate in the funeral service? ☐ Yes ☐ No

Name of Deceased:___________________________________ Date Deceased________________
Address:____
City:_______________________________ State:________________ Zip Code:_______________
Do you request the State Chaplain to send a sympathy card to the family of the deceased?
☐ Yes ☐ No
Name and Address of next of kin (for card only)____
____
Did you participate in the funeral service? ☐ Yes ☐ No

SICK LIST

Name of Comrade:__________________________________ Card requested: ☐ Yes ☐ No
Address:____ Card to ☐ Home ☐ Hospital
City:_______________________________ State:_________________ Zip Code:_______________
Date entered Hospital:___________________ Name of Hospital:____________________________
Address of Hospital:____
City:_______________________________ State:_________________ Zip Code:_______________
Did Post Chaplain or Officer visit Comrade during Hospitalization? ☐ Yes ☐ No

Name of Comrade:__________________________________ Card requested: ☐ Yes ☐ No
Address:____ Card to ☐ Home ☐ Hospital
City:_______________________________ State:_________________ Zip Code:_______________
Date entered Hospital:___________________ Name of Hospital:____________________________
Address of Hospital:____
City:_______________________________ State:_________________ Zip Code:_______________
Did Post Chaplain or Officer visit Comrade during Hospitalization? ☐ Yes ☐ No

Name of Comrade:__________________________________ Card requested: ☐ Yes ☐ No
Address:____ Card to ☐ Home ☐ Hospital
City:_______________________________ State:_________________ Zip Code:_______________
Date entered Hospital:___________________ Name of Hospital:____________________________
Address of Hospital:____
City:_______________________________ State:_________________ Zip Code:_______________
Did Post Chaplain or Officer visit Comrade during Hospitalization? ☐ Yes ☐ No

Name of Comrade:__________________________________ Card requested: ☐ Yes ☐ No
Address:____ Card to ☐ Home ☐ Hospital
City:_______________________________ State:_________________ Zip Code:_______________
Date entered Hospital:___________________ Name of Hospital:____________________________
Address of Hospital:____
City:_______________________________ State:_________________ Zip Code:_______________
Did Post Chaplain or Officer visit Comrade during Hospitalization? ☐ Yes ☐ No

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MONTLY TOTALS

Value of Flowers $___________________ Value of Fruit Baskets $_____________________

Cards sent:_______________ Hours:_______________ Mileage:_______________

NOTE: DO NOT REQUEST “GET WELL” CARDS TO BE SENT TO THE HOSPITAL, UNLESS THE COMRADE IS GOING TO BE THERE LONGTERM OR REHAB/NURSING CENTER. THANK YOU