

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name		Date Stamp	California 801 Form For Official Use Only
City of Long Beach			
Division, Department, or Region (if applicable)			
City Manager's Office			
Street Address			
333 W. Ocean Blvd., 13th Floor, Long Beach CA 90802			
Area Code/Phone Number	Email	<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)	
562-570-5091	tom.modica@longbeach.gov		
Agency Contact (name and title)			
Tom Modica, Assistant City Manager			

2. Donor Name and Address

Individual _____ Other Big Cities Health Coalition

_____ Last Name _____ First Name _____ Name _____

7501 Wisconsin Ave., Suite 1310E Bethesda MD 20814

Address _____ City _____ State _____ Zip Code _____

A forum for the leaders of the largest metropolitan health departments to promote and protect public health and safety.

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:

_____ \$ _____ Name _____ \$ _____

Name Amount Name Amount

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment Orlando, FL July 8-9, 2019

_____ Location of Travel _____ Dates (month, day, year) _____

American Airlines Rail Air Bus Auto Other Waldorf

_____ Transportation Provider _____ Check Applicable Boxes _____ Name of Lodging Facility _____

\$ 616.13 \$ 131.42 \$ 707.52 \$ 580.00 \$ 2,035.07

Lodging Expenses Meal Expenses Transportation Expenses Other Expenses Total Expenses

3.1 (b) Payment(s) not related to travel: N/A \$ _____

Dates (month, day, year) Total Expenses

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

Reimbursement for travel expenses related to participation in the Big Cities Health Coalition training and the 2019 NACCHO Annual Conference.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

<u>Lee</u>	<u>Ginger</u>	<u>Bureau Manager</u>	<u>Health & Human Services</u>
_____ Last Name	_____ First Name	_____ Position/Title	_____ Department/Division
_____ Last Name	_____ First Name	_____ Position/Title	_____ Department/Division

4. Verification

_____ reported payment(s) as in compliance with FPPC regulations.

Tom Modica Assistant City Manager 7/18/19

_____ Print Name _____ Title _____ (month, day, year)

Comment: _____
(Use this space or an attachment for any additional information)

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