

**VOUCHER FOR SMILE! CENTRAL OREGON**

Patient Name \_\_\_\_\_

Volunteer(s) Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Dates Worked \_\_\_\_\_ Hours Worked \_\_\_\_\_

Name of Non-Profit \_\_\_\_\_ PHONE #: \_\_\_\_\_

Authorized Signature From Organization \_\_\_\_\_

**FOR OFFICE USE ONLY APPROVED BY \_\_\_\_\_ DATE \_\_\_\_\_**

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