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STATE OF NEW HAMPSHIRE

Honorarium or Expense Reimbursement Report (RSA 15-B)



Type or Print all Information Clearly:

Name: FRANK G CASE Work Phone No. \_\_\_\_\_
First Middle Last

Work Address: \_\_\_\_\_

Office/Appointment/Employment held: \_\_\_\_\_

List the full name, post office address, occupation, and principal place of business, if any, of the source of any reportable honorarium or expense reimbursement. When the source is a corporation or other entity, the name and work address of the person representing the corporation or entity in making the honorarium or expense reimbursement must be provided in addition to the name of the corporation or entity.

RECEIVED

APR 09 2008

Source of Honorarium or Expense Reimbursement:

Name of source: GRATER SOUTHEAST DENTAL SOCIETY NEW HAMPSHIRE DEPARTMENT OF STATE
First Middle Last

Post Office Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Principal Place of Business: \_\_\_\_\_

If source is a Corporation or other Entity:

Name of Corporation or Entity: GREATER SOUTH EAST DENTAL SOCIETY

Name of Corporate/Entity Representative: \_\_\_\_\_

Work Address of Representative: \_\_\_\_\_

Food and/or beverages consumed pursuant to RSA 15-B:6, II with value over \$25.00 [checked]

Value of Honorarium: 35.00 Date Received: APR 8, 2008 If exact value is unknown, provide an estimate of the value of the gift or honorarium and identify the value as an estimate. [checked] Exact [ ] Estimate

Value of Expense Reimbursement: \_\_\_\_\_ Date Received: \_\_\_\_\_ A copy of the agenda or an equivalent document must be attached to this filing. [ ] Exact [ ] Estimate

Briefly describe the service or event this Honorarium or Expense Reimbursement relates to:

PROGRAM TO DESCRIBE THE ACTIVITIES IN THE COUNTY THE ASSOCIATION

"I have read RSA 15-B and hereby swear or affirm that the foregoing information is true and complete to the best of my knowledge and belief."

Signature of Filer: [Handwritten Signature]

Date Filed: APR 9, 2008