Incentive Gift Card Log

Health District _____ Date Sent _____

Please verify that the gift cards received match the card numbers listed on this log. Once verified, sign and date prior to distributing any gift cards. When all gift cards have been distributed, this log must be submitted to the TB Program by mail, encrypted email, or fax (804) 416-5178.

_____

Nurse Case Manager/Designee Name Signature

Date Received: _____

| Card Number | Gift Card Amount | Case Manager/Designee | Client Name | Date Given | Signed Client Gift Card Receipt |
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