

Recipient Committee Campaign Statement - Short Form

SEE INSTRUCTIONS ON REVERSE

Type or print in ink.

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SANTA CRUZ COLLECTIONS
Date Stamp
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SHORT FORM

CALIFORNIA FORM **450**

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For Official Use Only

For use by recipient committees that have not received a contribution or other receipt that must be itemized, have not received or made loans, and have no outstanding accrued expenses.

Statement covers period
from 7/1/2015
through 12/31/2015

Date of election if applicable
(Month, Day, Year)
11/3/2015

1. Type of Recipient Committee:

- Ballot Measure Committee
 Primarily Formed
 Controlled
 Sponsored
- General Purpose Committee
 Sponsored
 Small Contributor Committee
- Primarily Formed Candidate/Officeholder Committee

2. Type of Statement:

- Preelection Statement
 Semi-annual Statement
 Termination Statement
 Amendment (Explain) _____
(Also check type of statement you are amending)
- Quarterly Statement
 Special Odd-Year Report
 Supplemental Preelection Statement - Attach Form 495

3. Committee Information

I.D. NUMBER
820940

COMMITTEE NAME
CALIFORNIA SOCIETY FOR RESPIRATORY CARE POLITICAL ACTION COMMITTEE

STREET ADDRESS (NO P.O. BOX)

CITY STATE ZIP CODE AREA CODE/PHONE
WATSONVILLE CA 95076 (831) 763-2772

MAILING ADDRESS (IF DIFFERENT) NO. AND STREET OR P.O. BOX

CITY STATE ZIP CODE AREA CODE/PHONE

OPTIONAL: FAX / E-MAIL ADDRESS

Treasurer(s)

NAME OF TREASURER
Abbie Rosenberg

MAILING ADDRESS

CITY STATE ZIP CODE AREA CODE/PHONE
Watsonville CA 95076 (831) 722-3494

NAME OF ASSISTANT TREASURER, IF ANY

MAILING ADDRESS

CITY STATE ZIP CODE AREA CODE/PHONE

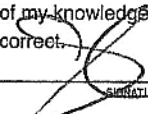
OPTIONAL: FAX / E-MAIL ADDRESS

Treasurer: arosenberg@csrc.org

4. Verification

I have used all reasonable diligence in preparing and reviewing this statement and to the best of my knowledge the information contained herein is true and complete. I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on 1/31/2016 DATE
 Executed on _____ DATE
 Executed on _____ DATE
 Executed on _____ DATE

By  SIGNATURE OF TREASURER OR ASSISTANT TREASURER
 By _____ SIGNATURE OF CONTROLLING OFFICERHOLDER, CANDIDATE, STATE MEASURE PROPONENT OR RESPONSIBLE OFFICER OF SPONSOR
 By _____ SIGNATURE OF CONTROLLING OFFICERHOLDER, CANDIDATE, STATE MEASURE PROPONENT
 By _____ SIGNATURE OF CONTROLLING OFFICERHOLDER, CANDIDATE, STATE MEASURE PROPONENT

Recipient Committee Campaign Statement Summary Page

Type or print in ink.
Amounts may be rounded
to whole dollars.

SHORT FORM

Statement covers period from <u>7/1/2015</u>	CALIFORNIA FORM 450
through <u>12/31/2015</u>	
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NAME OF COMMITTEE
CALIFORNIA SOCIETY FOR RESPIRATORY CARE POLITICAL ACTION COMMITTEE

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Expenditures Made

1. Expenditures of \$100 or more made this period	\$0.00
2. Expenditures under \$100 made this period (Not itemized.)	\$50.00
3. SUBTOTAL EXPENDITURES MADE THIS PERIOD	\$50.00
<i>Add Lines 1 + 2</i>	
4. Nonmonetary Adjustment	\$0.00
<i>From Line 8 Below</i>	
5. Total expenditures made from previous statement	\$1,935.96
<i>Previous Summary Page, Line 8</i>	
<i>(If this is the first statement for the calendar year, enter zero.)</i>	
6. TOTAL EXPENDITURES MADE TO DATE	\$1,985.96
<i>Add Lines 3 + 4 + 5</i>	

Contributions Received

7. Monetary contributions received this period	\$0.00
8. Non-monetary contributions received this period	\$0.00
9. Total contributions received from previous statement	\$0.00
<i>Previous Summary Page, Line 10</i>	
<i>(If this is the first statement for the calendar year, enter zero.)</i>	
10. TOTAL CONTRIBUTIONS RECEIVED TO DATE	\$0.00
<i>Add Lines 7 + 8 + 9</i>	

Current Cash Statement

11. Beginning cash balance	\$27,858.05
<i>Previous Summary Page, Line 15</i>	
12. Cash receipts this period	\$0.00
<i>Line 7 above</i>	
13. Miscellaneous increases to cash	\$6.00
14. Cash expenditures this period	\$50.00
<i>Line 3 above</i>	
15. ENDING CASH BALANCE THIS PERIOD	\$27,814.05
<i>Add Lines 11 + 12 + 13, then subtract Line 14</i>	

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5. Payments Made (If more space is needed, use additional copies of this page for continuation sheets.)

DATE*	NAME AND ADDRESS OF PAYEE (IF COMMITTEE, ALSO ENTER I.D. NUMBER)	DESCRIPTION OF PAYMENT	NAME OF CANDIDATE AND OFFICE OR NAME OF BALLOT MEASURE AND BALLOT NUMBER OR LETTER AND JURISDICTION	AMOUNT THIS PERIOD	Calendar Year
					CUMULATIVE AMOUNTS TO DATE*
			<input type="checkbox"/> Support <input type="checkbox"/> Oppose <input type="checkbox"/> Contribution <input type="checkbox"/> Ind. Exp.		<hr/> Other <hr/>
			<input type="checkbox"/> Support <input type="checkbox"/> Oppose <input type="checkbox"/> Contribution <input type="checkbox"/> Ind. Exp.		<hr/> Other <hr/>
			<input type="checkbox"/> Support <input type="checkbox"/> Oppose <input type="checkbox"/> Contribution <input type="checkbox"/> Ind. Exp.		<hr/> Other <hr/>
SUBTOTAL \$					

* Required only for payments which are contributions or independent expenditures.