



FORM
GD1
(Rev. 5/2013)

Hawaii State Ethics Commission Received
5/5/2016 7:50:01 AM



HAWAII STATE ETHICS COMMISSION GIFTS DISCLOSURE STATEMENT

(This report covers the period from June 1 of the preceding calendar year through June 1 of this year and is due by June 30)

FILER

DOMINGO	DARLENE	B
Last Name	First Name	M.I.
HILO MEDICAL CENTER	RN,BSN, CWCN	
State Agency	State Position	

CONTACT INFORMATION

DARLENE DOMINGO
1190 WAINUENUE AVE
Number and Street or P.O. Box

HILO	HI	96720
City	State	Zip Code
808-932-2595	ddomingo@hsc.org	
Telephone	Extension	Email Address

GIFT INFORMATION (LIST EACH GIFT SEPARATELY)

- | | |
|--|-------------------------------------|
| 1. Donor: <u>ACELITY</u> | Date Received: <u>03/04-07/2015</u> |
| Gift (Description): <u>FOOD</u> | Value/Cost: <u>150.00</u> |
| 2. Donor: <u>ACELITY</u> | Date Received: <u>03/04-07/2015</u> |
| Gift (Description): <u>HOTEL</u> | Value/Cost: <u>600.00</u> |
| 3. Donor: <u>ACELITY</u> | Date Received: <u>03/04-07/2015</u> |
| Gift (Description): <u>TRAVEL -AIRLINE</u> | Value/Cost: <u>1230.00</u> |
| 4. Donor: _____ | Date Received: _____ |
| Gift (Description): _____ | Value/Cost: _____ |
| 5. Donor: _____ | Date Received: _____ |
| Gift (Description): _____ | Value/Cost: _____ |

Check here if additional sheets are attached

FILER

<u>DARLENE B. DOMINGO</u>	<u>05/05/2016</u>
Print Name of Filer (First M.I. Last)	Date (m/d/yyyy)

CERTIFICATION: By checking this box, you signify and affirm that you are the person whose name appears as the "Filer" above and the information contained in the form is true, correct and complete to the best of your knowledge and belief. You further certify that you understand that there are statutory penalties for failing to report the information required by Hawaii law.