

Candidate's Name _____

Home Mailing Address _____

City _____ State _____ ZIP _____

County _____ Phone (_____) _____

Credentials (Certifications, etc.)

RN MD/DO EMT # _____ Agency # _____

CFR EMT-B EMT-I EMT-CC EMT-P Instructor (Level) _____

Other Credentials _____

EMS Affiliation/Organizations

Name of Organization _____

Address _____

City _____ State _____ ZIP _____

Role/Title _____ Phone (_____) _____

Indicate the category for which the applicant is being nominated (See awards brochure description and criteria)

Basic Life Support Provider of the Year EMS Communications Specialist of the Year

Advanced Life Support Provider of the Year Excellence in EMS Quality and Safety

EMS Agency of the Year Registered Professional Nurse of Excellence

Youth Provider of the Year Physician of Excellence

Harriet C. Weber EMS Leadership Award Commissioner of Health's Award of Excellence

EMS Educator of Excellence

Reasons for Information

USE THE REVERSE SIDE OF THIS FORM ONLY.

Describe why candidate should receive this award. Applications must be typewritten to be considered.

Name of Person or Agency Submitting Nomination _____

Home Phone (_____) _____ Work Phone (_____) _____

Regional Council Chairperson Approval _____
SIGNATURE

Regional Council Name _____

It is your responsibility to discuss this nomination with your candidate, for his/her acceptance.

Application must be typewritten in a font no less than 12 points.

EMS Background

Reason for Award Nomination

Contribution/Impact to EMS
