

Candidate's Name _____

Home Mailing Address _____

City _____ State _____ ZIP _____

County _____ Phone (_____) _____

Email _____

Credentials (Certifications, etc.)

EMT # _____ Agency # _____ Instructor (Level) _____

CFR EMT A-EMT EMT-CC EMT-P RN PA MD/DO

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)

- | | |
|---|---|
| <input type="checkbox"/> Basic Life Support Provider of the Year | <input type="checkbox"/> EMS Communications Specialist of the Year |
| <input type="checkbox"/> Advanced Life Support Provider of the Year | <input type="checkbox"/> Excellence in EMS Quality and Safety |
| <input type="checkbox"/> EMS Agency of the Year | <input type="checkbox"/> EMS Clinical Partner of Excellence |
| <input type="checkbox"/> Youth Provider of the Year | <input type="checkbox"/> Physician of Excellence |
| <input type="checkbox"/> Harriet C. Weber EMS Leadership Award | <input type="checkbox"/> Commissioner of Health's Award of Excellence |
| <input type="checkbox"/> 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.

Applications must be received in the portal by July 1.

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

EMS Background

Reason for Award Nomination

Contribution/Impact to EMS

Applications must be received in the portal by July 1.
