NEW YORK STATE DEPARTMENT OF HEALTH

Emergency Medical Services Bureau

Application for the New York State EMS Council Annual Awards

CFR	Candidate's	name:						
County:								
redentials (certifications, etc.) RN								
REASONS FOR NOMINATION (describe on back why candidate should receive this award). Regional Council Chairperson Approval: Agency #:					Phone Number: ()			
REASONS FOR NOMINATION (describe on back why candidate should receive this award). Regional Council Chairperson Approval: Agency #:								
CFR	Credentials (ce	ertifications, etc.)						
MS Affiliation/Organizations Name of Organization: Address of Organization: City: State: Zip: Phone Number: ()	\square RN	□ MD/DO	EMT #:		Agency #:			
MS Affiliation/Organizations Name of Organization:	☐ CFR	□ ЕМТ-В	☐ EMT-I	☐ EMT-CC	☐ EMT-P	☐ Instructor ((level):	
Name of Organization:	Other creden	tials:						
Name of Organization:	EMS Affiliation	n/Organizations						
Address of Organization: City: State: Zip: Phone Number: ()		_						
City: State: Zip:Phone Number: ()		-						
Role/Title:								
NDICATE THE CATEGORY FOR WHICH THE APPLICANT IS BEING NOMINATED (See awards brochure description and criteria). Basic Life Support								
Basic Life Support	INDICATE THE	CATECORY FOR MU	ICH THE ADDITO	NT IC DEING NOME	NATED (See assemble	huashiina dassiintian an	المشاهدة الم	
Provider of the Year Advanced Life Support Provider of the Year Commissioner of Health's Award of Excellence REASONS FOR NOMINATION (describe on back why candidate should receive this award). Applications must be typewritten to be considered. USE THE REVERSE SIDE OF THIS FORM ONLY. No other attachments will be accepted. Name of person or agency submitting nomination: Phone Number: home: ()						·		
Provider of the Year Leadership Award Specialist of the Year Commissioner of Health's Award of Excellence REASONS FOR NOMINATION (describe on back why candidate should receive this award). Applications must be typewritten to be considered. USE THE REVERSE SIDE OF THIS FORM ONLY. No other attachments will be accepted. Name of person or agency submitting nomination: Phone Number: home: () work: ()							Nurse of Excellence	
REASONS FOR NOMINATION (describe on back why candidate should receive this award). Applications must be typewritten to be considered. USE THE REVERSE SIDE OF THIS FORM ONLY. No other attachments will be accepted. Name of person or agency submitting nomination: Phone Number: home: () work: () Regional Council Chairperson Approval: **Signature** **Signature**	Advanced Life Support Provider of the Year						☐ Physician of Excellence	
Applications must be typewritten to be considered. USE THE REVERSE SIDE OF THIS FORM ONLY. No other attachments will be accepted. Name of person or agency submitting nomination:				☐ Commissioner o	of Health's Award o	of Excellence		
USE THE REVERSE SIDE OF THIS FORM ONLY. No other attachments will be accepted. Name of person or agency submitting nomination:			REASONS FO	OR NOMINATION (de:	scribe on back why car	ndidate should receive this	s award).	
Name of person or agency submitting nomination:work: () Phone Number: home: ()work: () Regional Council Chairperson Approval:	Applications	must be typewritte	en to be conside	red.				
Phone Number: home: ()work: () Regional Council Chairperson Approval:	USE THE R	EVERSE SIDE OF	THIS FORM ON	LY. No other attac	hments will be a	ccepted.		
Regional Council Chairperson Approval:	Name of person or agency submitting nomination:							
	Phone Num	ber: home: ()		work: ()		
	Regional Co	ouncil Chairperson	Approval:			sianatura		
Regional Council Name:								
	Regional Co	ouncil 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.

Please summarize the reason why this nominee should receive the award.
EMS Background:
Reason for award nomination:
Contribution/Impact to EMS: