NEW YORK STATE DEPARTMENT OF HEALTH
Emergency Medical Services Bureau

Application for the New York State EMS Council Annual Awards

Candidate's name: _____

Home mailing address: _____

City: _____ State: _____ Zip: _____

County: _____ Phone Number: ( ) _____

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 of Organization: _____

City: _____ State: _____ Zip: _____ Phone Number: ( ) _____

Role/Title: _____

INDICATE THE CATEGORY FOR WHICH THE APPLICANT IS BEING NOMINATED (See awards brochure description and criteria).

☐ Basic Life Support Provider of the Year

☐ EMS Agency of the Year

☐ EMS Educator of Excellence

☐ Registered Professional Nurse of Excellence

☐ Advanced Life Support Provider of the Year

☐ Harriet C. Weber EMS Leadership Award

☐ EMS Communications Specialist of the Year

☐ Physician of Excellence

☐ 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: ( ) _____

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 POSTMARKED NO LATER THAN AUGUST 1

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: