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| **WONCA AWARD OF EXCELLENCE IN HEALTH CARE****“The 5-Star Doctor”** |

**NOMINATION FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| **A.** | **Details of person being nominated** |  |  |
|  | *Last Name:* |  |  |
|  | *First Name:* |  |  |
|  | *Initials:* |  |  |
|  | *Title:* |  |  |
|  | *Postal Address:* |  |  |
|  | *Physical Address is different:* |  |  |
|  | *Tel No:* |  |  |
|  | *Fax No:* |  |  |
|  | *Email address:* |  |  |
|  | *Name of Organisation / Institution (if any):* |  |  |
|  | *Postal Address of Organisation / Institut’:* |  |  |
|  | *Position held in Organisation / Institut’:* |  |  |
|  | *Fax / Email of organization/institution:* |  |  |
|  | *Date of birth:* |  |  |
|  |  |  |  |
| **B.** | **Primary person making the nomination** |  |
|  | *Last Name* |  |  |
|  | *First Name* |  |  |
|  | *Initials* |  |  |
|  | *Title* |  |  |
|  | *Address* |  |  |
|  | *Tel No:* |  |  |
|  | *Fax No:* |  |  |
|  | *Email address:* |  |  |
|  | *Position / Status:* |  |  |
|  | *Relationship to nominee:* |  |  |
|  |  |  |  |
| **C.** | **FULL description of the nominee’s activities which have motivated this nomination. Include how this person has made an impact on individuals and communities; on regional and local development of services; any academic activities instituted/completed; and any innovative activities, which may have been instituted. *(Attach any supportive documents)*** |  |
|  | *(This space will automatically expand if completed on computer.)* |  |
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| **D.** | **Other information:** |  |  |
|  | *Is the nominee still involved in these activities? (Explain)* |  |  |
|  | *Does/did the nominee work in collaboration with others? – If “Yes” please explain and give contact details* |  |  |
|  | *Has the work been described in published articles? If so give details* |  |  |
|  | *Has the nominee been honoured in any other way for this work/activity? Give details* |  |  |
|  | *Has the nominee been nominated previously?* |  |  |
|  | *Does the nominee have knowledge of your nomination?* |  |  |
|  |  |  |  |
| **E.** | **Other person/s who could be contacted to obtain further information on the nominee.** |  |
| *1.* | *Name* |  |  |
|  | *Address* |  |  |
|  | *Email address (Fax)* |  |  |
|  | *Position:* |  |  |
|  |  |  |  |
| *2.* | *Name* |  |  |
|  | *Address* |  |  |
|  | *Email address (Fax)* |  |  |
|  | *Position:* |  |  |
|  |  |  |  |
| **F.** | **In making this nomination I acknowledge that the decision by the judges is final and not subject to review. I am also prepared to supply any additional information if required.** |  |
|  | *Name:* |  |  |
|  | *Best contact address or email address:* |  |  |
|  |  |  |  |

Return to: Wonca Europe Secretariat, Institute for development of Family Medicine

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E-mail: SecretariatEurope@Wonca.net, Fax: +386 1 438 69 10