

# PENNSYLVANIA ASSOCIATION OF PERIANESTHESIA NURSES



## Patient Advocate Award Nominee Form

**STEP TWO:** To be completed by nominee. Please avoid abbreviations.

Full Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Current Position: \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

Entry Nursing Degree from: \_\_\_\_\_

( ) AD ( ) Diploma ( ) BSN City: \_\_\_\_\_ State: \_\_\_\_\_

Additional Degree(s): (List degree and institution). \_\_\_\_\_

\_\_\_\_\_

Professional Certification(s): \_\_\_\_\_

Professional Organizational membership(s), honors, awards: \_\_\_\_\_

\_\_\_\_\_

I agree to be considered for the PAPAN Patient Advocate Award sponsored by the Pennsylvania Association of Perianesthesia Nurses (PAPAN). I agree to participate in the awards program, if chosen. I understand the Awards Committee may contact my present employer, and I authorize said employer to release information pertinent to such a request.

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Mail to: Chair, Membership Committee  
Refer to PAPAN website for mailing address

Postmarked no later than  
February 1<sup>st</sup>