



**VETERANS OF FOREIGN WARS  
OUTSTANDING COMMUNITY HEALTH CARE  
EMPLOYEE OF THE YEAR AWARD**

**NOMINEE FORM**

NAME OF NOMINEE: \_\_\_\_\_  
POSITION OR TITLE: \_\_\_\_\_  
ADDRESS OF NOMINEE: \_\_\_\_\_  
CITY AND STATE: \_\_\_\_\_  
PHONE: \_\_\_\_\_

NAME OF FACILITY: \_\_\_\_\_  
ADDRESS OF FACILITY: \_\_\_\_\_  
CITY AND STATE: \_\_\_\_\_  
DIRECTOR: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_

SUBMITTED BY POST: \_\_\_\_\_  
POST COMMANDER: \_\_\_\_\_  
POST HOSPITAL CHAIRMAN: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_

SUBMITTED BY DEPARTMENT: \_\_\_\_\_  
DEPARTMENT COMMANDER: \_\_\_\_\_  
DEPARTMENT HOSPITAL CHAIRMAN: \_\_\_\_\_

Provide a brief summary (not to exceed two pages) explaining the **who, what, where, when** and **how** the nominee's efforts assisting veterans and their families are considered exemplary.

Nominee forms must be submitted through the Department for competition so **only one nomination in each category can be forwarded by the Department Adjutant to the Director, NVS** for National Competition.

**NOTE:** Nominees forms must be forwarded by Departments to the Washington, D.C. office no later than March 28, 2008.



**VETERANS OF FOREIGN WARS  
OUTSTANDING HEALTH CARE VOLUNTEER  
OF THE YEAR AWARD**

**NOMINEE FORM**

**NAME OF NOMINEE:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**CITY AND STATE:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_

**NAME OF FACILITY:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_  
**FACILITY COORDINATOR:** \_\_\_\_\_

**SUBMITTED BY POST:** \_\_\_\_\_  
**POST COMMANDER:** \_\_\_\_\_  
**POST HOSPITAL CHAIRMAN:** \_\_\_\_\_  
**PHONE NUMBER:** \_\_\_\_\_

**SUBMITTED BY DEPARTMENT:** \_\_\_\_\_  
**DEPARTMENT COMMANDER:** \_\_\_\_\_  
**DEPARTMENT HOSPITAL CHAIRMAN:** \_\_\_\_\_  
**DEPARTMENT TELEPHONE NUMBER:** \_\_\_\_\_

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**VETERANS OF FOREIGN WARS  
OUTSTANDING VA HEALTH CARE EMPLOYEE  
OF THE YEAR AWARD**

**NOMINEE FORM**

NAME OF NOMINEE: \_\_\_\_\_  
POSITION OR TITLE: \_\_\_\_\_  
ADDRESS OF NOMINEE: \_\_\_\_\_  
CITY AND STATE: \_\_\_\_\_  
PHONE: \_\_\_\_\_

NAME OF FACILITY: \_\_\_\_\_  
ADDRESS OF FACILITY: \_\_\_\_\_  
CITY AND STATE: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_  
DIRECTOR: \_\_\_\_\_

SUBMITTED BY POST: \_\_\_\_\_  
POST COMMANDER: \_\_\_\_\_  
POST HOSPITAL CHAIRMAN: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_

SUBMITTED BY DEPARTMENT: \_\_\_\_\_  
DEPARTMENT COMMANDER: \_\_\_\_\_  
DEPARTMENT HOSPITAL CHAIRMAN: \_\_\_\_\_

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