2020 Migrant Health Awards

Principal Nomination Form

TO BE COMPLETED BY THE PRINCIPAL NOMINATOR; FOLLOW THE INSTRUCTIONS IN COMPLETING STEPS 1-6:

1. Please indicate the award for which you are submitting a nomination:
   - [ ] Migrant Health Center Award
   - [ ] Outstanding Migrant Health Center Board Member Award
   - [ ] Outstanding Migrant Health Public Service Award
   - [ ] Lifetime Achievement in Migrant Health Award

2. Please complete the following information regarding your selected nominee:
   Name: ____________________________________________
   Title: ____________________________________________
   Health Center/PCA Affiliation: __________________________
   (If non-applicable, please list respective organization)
   Mailing Address  [ ] organization  [ ] personal: ____________________________
   City: ____________________________ State: ____________ Zip: ____________
   Telephone Number: ____________________________ NACHC Individual Member Number: __________________

3. Please complete the following information regarding you, the nominator:
   Name: ____________________________________________
   Title: ____________________________________________
   Health Center/PCA Affiliation: __________________________
   (If non-applicable, please list respective organization)
   Mailing Address  [ ] organization  [ ] personal: ____________________________
   City: ____________________________ State: ____________ Zip: ____________
   Telephone Number: ____________________________

4. Please write a nomination statement:
   On a separate sheet, draft a detailed description of why you think the nominee should receive the selected award. Responses should be typed and no longer than one page. The statement should explain how the nominee meets the specific award criteria to merit recognition. Attach the statement to the nomination form.

5. Please obtain two completed supporting nomination forms (see Attachments A & B):
   Each Principal nomination must be supported by two additional nominations from other individuals. These forms must be included in the nomination package in order for the nomination to be considered complete.

6. Submit your completed nomination package:
   My completed nomination package includes all of the required items listed below:
   - [ ] Principal Nomination Form
   - [ ] Nomination Statement – 1 page typed
   - [ ] Supporting Nomination Form (A)
   - [ ] Supporting Nomination Form (B)

Susan Hansen, NACHC, 7501 Wisconsin Ave., Suite 1100W, Bethesda, MD 20814, email: shansen@nachc.com
2020 Migrant Health Awards

Supporting Nomination Form—Attachment A

THIS FORM IS TO BE COMPLETED BY THE SUPPORTING NOMINATOR

1. Please complete the following information regarding you, the supporting nominator:

   Name: ____________________________________________

   Title: ____________________________________________

   Health Center/PCA Affiliation: ________________________________
   (if non-applicable, please list respective organization)

   Mailing Address ☐ organization ☐ personal: ________________________

   City: ___________________________ State: ___________ Zip: _______________

   Telephone Number: ________________________________

2. I fully support the nomination of: ________________________________ [nominee’s name]

   for a NACHC 2020 Migrant Health Award.

3. My signature below indicates my full support:

   __________________________________________________________ [signature]

Return this form to the principal nominator for inclusion in the completed Nomination packet that will be submitted to NACHC
2020 Migrant Health Awards

Supporting Nomination Form—Attachment B

THIS FORM IS TO BE COMPLETED BY THE SUPPORTING NOMINATOR

1. Please complete the following information regarding you, the supporting nominator:

   Name: ______________________________________________________________

   Title ______________________________________________________________

   Health Center/PCA Affiliation: ______________________________________
   (if non-applicable, please list respective organization)

   Mailing Address ☐ organization ☐ personal: _______________________

   City: ____________________________ State: __________ Zip: _____________

   Telephone Number: __________________________

2. I fully support the nomination of: ____________________________ [nominee’s name]
   for a NACHC 2020 Migrant Health Award.

3. My signature below indicates my full support:

   _______________________________ [signature]

Return this form to the principal nominator for inclusion in the completed
Nomination packet that will be submitted to NACHC
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ELIGIBILITY REQUIREMENTS

MIGRANT HEALTH CENTER AWARD
This award is presented to a migrant health center which has demonstrated an outstanding level of excellence in the migrant health care field. Organizational candidates for the Migrant Health Center Award must have demonstrated a high level of commitment and innovation in service to migrant farmworkers and their families.

Eligibility: A Migrant Health Center which is a NACHC Organizational member in good standing.

OUTSTANDING MIGRANT HEALTH CENTER BOARD MEMBER AWARD
This award is presented to an individual who has demonstrated an outstanding level of service and commitment as a board member of a migrant health center.

Eligibility: A board member of a migrant health center which is a NACHC Organizational Member in good standing. NACHC Individual Membership is not required.

OUTSTANDING MIGRANT HEALTH PUBLIC SERVICE AWARD
This award is presented to an individual who has made significant contributions to the migrant health care field either: (1) as an official in a legislative or administrative branch of government or other public or private agency or (2) as a migrant health center leader who has been highly effective in the public policy arena.

Eligibility: An individual who serves in the public policy areas of local, state or federal government or other public or private agency or a staff or board member of a migrant health center which is a NACHC Organizational member in good standing. NACHC Individual Membership is not required for a public official.

LIFETIME ACHIEVEMENT IN MIGRANT HEALTH AWARD
This award is presented to an outstanding individual who has demonstrated long term commitment and excellence in migrant health.

Eligibility: An individual that has served in the migrant health field for 15 years or more. NACHC Individual membership is required.