NOMINATION FORM

I would like to nominate ___________________________________ from the _________________________ unit/department as a deserving recipient of The DAISY Award. This nurse’s clinical skill and especially her/his compassionate care exemplify the kind of nurse that our patients, their families, and our staff recognize as an outstanding role model. She/he consistently meets all of the following criteria:

• Exceeds expectations  
• Promotes a culture of excellence  
• Builds healthy relationships  
• Commitment to advancing the profession of nursing

Please describe a situation involving the nurse you are nominating that clearly demonstrates he/she meets the criteria for the DAISY Award:  _________________________________________________________________________________________  
_______________________________________________________________________________________________________  
_______________________________________________________________________________________________________  
_______________________________________________________________________________________________________  
_______________________________________________________________________________________________________  
_______________________________________________________________________________________________________  

Thank you for taking the time to nominate an extraordinary nurse for this award. Please provide us with the following information:

Your Name ________________________________________________ Unit _____________  Phone ___________________

I am (please check one):  RN_____  Patient _____  Family/Visitor _____  MD _____  Staff ____  Volunteer _____

Date of nomination  ________________________________

Please submit this nomination to Community Memorial Hospital, Nursing Administration – DAISY Award, W180 N8085 Town Hall Road, Menomonee Falls, WI 53051 or the completed nomination form may be dropped off at the front Information Desk. If you have any questions, please contact Angela Hoeppner, RN, Nursing Administration, at 262-257-3015 or via email at ahoeppne@communitymemorial.com.

(Hospital Completes this) Manager Acknowledgement
I acknowledge that this nurse is in good standing.

Signed: ________________________________  Title _______________________________

F-1952 (10/08)