



Hall of Fame NOMINATION FORM

Name _____
Address (if living) _____
City/ST/Zip _____

Birth date (if known) _____
Telephone _____

Please outline the nominee's life and personal accomplishments.

Please outline the nominee's achievements and/or contributions to health care.

Please include the following information about the nominee:

Education/training _____

Awards/honors _____

Memberships _____

Professional/vocational experiences _____

Family history (optional) _____

Nomination submitted by _____ *Telephone* _____

Relationship to nominee _____

Deadline for submission: Second Friday of February of each year

Return to: Ottumwa Regional Health Foundation, Inc.
935 Pennsylvania
Ottumwa, IA 52501