

Westchester County Board of Health
Dr. Harold Keltz Distinguished Public Health Service Award

2018 NOMINATION FORM

ELIGIBILITY: Nominees must live or work in Westchester County

CRITERIA: Nominees should be an individual or organization whose efforts have made an extraordinary contribution to public health in Westchester

FILING DEADLINE: **February 19, 2018**

MAIL OR DELIVER TO: Westchester County Board of Health
Public Health Awards
C/o Caren Halbfinger
Cqh4@westchestergov.com Subject Line: 2018 Nomination
Westchester County Department of Health
145 Huguenot Street, 7th Floor
New Rochelle, New York 10801

1. NOMINEE INFORMATION (Use N/A where not applicable) Email a color photo and a completed photo release form.

Nominee's name; if nominee is an organization, please also provide name of contact person	Title
Address	
Email	Phone
Funding Source	Partner Agencies

2. PUBLIC HEALTH CONTRIBUTIONS: Use the reverse side of this form or attach your remarks to describe the nominee's accomplishments and contributions to public health in Westchester. Attach multimedia examples and links as needed.

3. PERSON MAKING THE NOMINATION

Name	Agency (if applicable)
Address	Phone and email
Signature	Date

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PUBLIC HEALTH CONTRIBUTIONS OF NOMINEE

A large, empty rectangular box with a thin black border, occupying the majority of the page below the section header. It is intended for the user to write the nominee's public health contributions.



PHOTO RELEASE FORM

Participant's Name: _____

I hereby authorize Westchester County Department of Health to publish the photographs and/or video taken of me and/or my child(ren), along with our names, for use in WCHD's printed publications, website, Facebook page and Twitter and to share with the public.

I acknowledge that my participation is voluntary and I will receive no financial compensation.

I further agree that my participation in any video, publication or website produced by Westchester County Health Department confers upon me no rights of ownership whatsoever. I release Westchester County Health Department and its employees from liability for any claims by me or any third party in connection with my participation.

Signature: _____ Date: _____

Street Address: _____

City, State, Zip: _____

Minor Children:

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

FORMULARIO DE AUTORIZACIÓN DE LA FOTO

Nombre del participante: _____

Por la presente autorizo a Westchester County Departamento de salud para publicar las fotografías tomadas de mí o mi hijo (a), junto con nuestros nombres, para uso en publicaciones imprimidas por WCHD, en el website, página de Facebook y Twitter.

Reconozco que mi participación en publicaciones y Website producidas por el Departamento de salud del Condado de Westchester es voluntaria. Yo no recibiré ninguna compensación económica.

Además acepto que mi participación en cualquier publicación y website producida por el Departamento de salud del Condado de Westchester no confiere sobre mí ningún derecho de propiedad alguna. Yo libero a Westchester County Health Department y sus empleados de responsabilidad por cualquier reclamación por mí o cualquier tercero en relación con mi participación.

Firma: _____ Fecha: _____

Dirección residencial: _____

Ciudad, Estado, Código postal: _____

Niños Menores:

Nombre: _____ Edad: _____

Nombre: _____ Edad: _____

Nombre: _____ Edad: _____

Nombre: _____ Edad: _____

Nombre: _____ Edad: _____

DEPARTMENT OF HEALTH