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 11, 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

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 participationt 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_____

DEPARTMENT OF HEALTH

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:_____

Direccion residencial: _____

Ciudad, Estado, Codigo postal: _____

Niños Menores:

Nombre: _____ Edad: _____

Nombre: _____ Edad: _____

Nombre: _____ Edad: _____

Nombre: _____ Edad: _____

Nombre: _____ Edad: _____

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