

FOUNDER'S AWARD

Nominees should be or have been active and contributing members of the MWACSM chapter. Recipients will receive an acknowledgement of their dedication and professional contributions. It will be presented at the Annual Meeting.

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Current Position: _____

Currently MWACSM Affiliated: Yes No

Initial Year of Affiliation: _____ Total Years Affiliated: _____

What has the applicant done for MWACSM?

(Use another page if necessary)

In addition to the information required above, please consider letters of endorsement from the applicant's peers, patients, clients or others.

Enclosed are letters from (check all that apply):

_____	Peer(s)	_____	Patient(s)/Client(s)
_____	Superior(s)/Supervisor(s)	_____	Other

Please list: _____

****The information below is completely optional and will be confidential if requested.***

Nominee's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____