

Association of Black Health-system Pharmacists

AWARDS RECOMMENDATION FORM

Assessment of the Candidate's Contributions, Performance, and Leadership

Candidate's First Name	Initial	Last Name
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Mailing Address

City	State	ZipCode
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Recommender Name

Mailing Address

City	State	ZipCode
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Affiliation	Daytime Phone (Area Code + Number)
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Title	Email
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Candidate's professional relationship to you:

Length of time of relationship with candidate:

1. Please select the Award in which the candidate is being nominated:

- | | |
|---|--|
| <input type="checkbox"/> Meritorious Service | <input type="checkbox"/> Student Achievement |
| <input type="checkbox"/> Pharmacist of the Year | <input type="checkbox"/> Research & Publication Achievement |
| <input type="checkbox"/> Distinguished Service | <input type="checkbox"/> Pharmacy Technician of the Year |
| <input type="checkbox"/> Industry Relations | <input type="checkbox"/> Wendell T. Hill Award |
| <input type="checkbox"/> Pharmaceutical Care | <input type="checkbox"/> Outstanding Pharmacy Resident Award |

2. Pharmacy School: _____ **Year Graduated:** _____

If currently a student, indicate classification:

- | | |
|--|--|
| <input type="checkbox"/> 1 st Professional Year | <input type="checkbox"/> 4 th Professional Year |
| <input type="checkbox"/> 2 nd Professional Year | <input type="checkbox"/> 5 th Professional Year |
| <input type="checkbox"/> 3 rd Professional Year | <input type="checkbox"/> 6 th Professional Year |

Grade Point Average (GPA, for students only) _____

RECOMMENDATION: The individual named above is being nominated for ABHP Awards via the ABHP Awards and Recognition Program. The program is intended to stimulate practice innovations, quality performance, and leadership among ABHP members.

TO THE RECOMMENDER: Please print or type the nominee's name and address in the spaces provided above. This form should be completed by an individual (i.e., practitioner, administrator, supervisor, preceptor, or academician) familiar with the nominee's contributions as a practitioner who can attest to the nominee's professional achievement, performance, and leadership ability.

This recommendation is to be mailed, E-Mail, or FAX directly to the Chairperson, Professional Affairs Council. (Photocopy additional forms as needed).

Please mail or FAX recommendation form and attached statement to:

Vivian Johnson, PharmD
Parkland Memorial Hospital
5201 Harry Hines Blvd
Dallas, Texas 75235
(214) 590-8299 (work)
(214) 590-6917 (FAX)
E-Mail: vbjohn@parknet.pmh.org

As part of the review process, the Awards Committee will also consider additional comments you submit regarding this individual. Please feel free to respond to the following questions as thoroughly as possible:

1. In your opinion, what has been the quality of the candidate's contributions, performance and leadership abilities?

Signature of Recommender

Date

Thank you for your assistance.