

Nomination Form

Continuing Care Representative to the Health Association Continuing Care Council

Name of Nominee: _____
Position: _____
Phone: _____ Email: _____

ORGANIZATION INFORMATION

Organization Name : _____

- Organization Type:
- Nursing Home / Home for the Aged
 - Home Support / Home Care
 - Adult Residential / Regional Rehab Centre

- Geographic Location:
- South Shore (DHA 1, 2, 3)
 - Colchester / Cumberland (DHA 4, 5, 6)
 - Antigonish / Cape Breton (DHA 7, 8)
 - Capital (DHA 9)

- Ownership Type:
- Private ownership
 - Community governed

of Clients / Residents: _____

NOMINEE INFORMATION

years experience in a continuing care management function: _____

Please describe the individual under the following categories:

Leadership: _____

Connectiveness: _____

Commitment: _____

Description of other extracurricular activities the nominee has been / is involved in (e.g. committees, working groups):

Other comments: _____

Name of Nominator: _____ Date: _____

Position: _____

The information provided will be used to assist the Nominating Committee in making a recommendation to Council.

Please fax nomination to Carol Salkin at (902) 832-8505 or by email to carol.salkin@healthassociation.ns.ca