SAN ANTONIO REGIONAL HOSPITAL

SAN ANTONIO

PROVIDER AWARD

NOMINATION FORM

The PROVIDER Award recognizes all members of the Medical Staff, who contribute to an exceptional patient, family, and care team member experience through their dedication to ***Excellence with Compassion.***

ELIGIBILITY: Nominees are members of the San Antonio Medical Staff.

CRITERIA: Nominees consistently exhibit the following San Antonio provider characteristics:

- » Teaching/mentoring spirit
- » Consistently shows respect and dignity
- » Goes above and beyond expectations

Nominee Name:		Department/Unit:	
Your Name:		Email:	
Phone Number:		Date:	

I am a (please check one): ❑ San Antonio Care Team Member* ❑ Patient ❑ Family/Visitor

*Physician, Employee, Volunteer

❑ I grant permission to use the information in my nomination, and I understand that minor editing may be necessary to comply with the hospital's policies, such as the HIPAA Privacy Policy.

The following situation clearly illustrates my nominee meets the Provider Award criteria, while demonstrating one of more of the following hospital values:

❑ Patient-centered ❑ Compassion ❑ Integrity ❑ Safety ❑ Respect ❑ Excellence

Medical Staff Acknowledgement:

❑ I acknowledge this nominee is in good standing.

Name: Title: