



**MEDICAL BOARD OF CALIFORNIA**  
**Executive Office**



**PHYSICIAN HUMANITARIAN AWARD**  
**NOMINATION FORM**

Name of nominee(s): \_\_\_\_\_

Name of project or employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Please answer the following questions on separate sheets and attach any additional supporting materials to the nomination form:

- Describe the nominee’s project/service, including purpose, focus, goals, results and impact to the community and the medical profession, and dates of service.
- Describe the organization and/or program through which the nominee served.
- Describe how and why the service/project fits within award criteria, and the effect it had on the community.
- Describe the nominee’s principal areas of practice and any specialty board certification.
- Please list the nominee’s memberships in local, state, national associations and/or professional organizations.

Please provide any additional information that you believe is important to the consideration of this nominee.

Name of nominator: \_\_\_\_\_

Relationship to nominee: \_\_\_\_\_

Employer, organization or medical group: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Mail nomination form and supporting materials to:

Medical Board of California  
Attention: Physician Recognition Committee  
2005 Evergreen Street, Suite 1200  
Sacramento, CA 95815

916/263-2389  
[www.mbc.ca.gov](http://www.mbc.ca.gov)