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| print_color_medium.png | **ACADEMY OF ASSOCIATEDEGREE NURSING** **HONORARY NOMINATION** |
| **HONORARY ACADEMY MEMBER NOMINATION**  |
| First Name: Last Name: |
| Credentials: Current Position:  |
| School or Employer:  |
| School/Employer City & State:  |
| Preferred Mailing Address: \_\_Home \_\_Work |
| City: State/Territory/Province:  |
| Zip/Postal Code: Country:  |
| Phone Number: \_\_Home \_\_\_ Cell \_\_\_Work |
| Email Address:  |
| Nominated By: Nominator’s OADN Member #:  |
| Nominator’s Email Address:  |
| Nominator’s Phone Number:  |
|  Will attend induction ceremony at the OADN National Convention in November, if selected. |

The honorary academy fellowship recognizes those individuals who have worked to transform health and education through associate degree nursing throughout the breadth of their careers. Honorary fellows have worked in education and practice, as well as other fields such as advocacy and service**. (Does not include individuals who are actively engaged in associate degree nursing education or practice.)**

**A complete Academy of Associate Degree Nursing Honorary Member nomination packet includes:**

* A statement of no more than 750 words from the nominator stating the reasons the individual should be considered for honorary membership. Include how the individual has contributed to **associate degree** **nursing education** in **one** of following areas:
* Innovative strategies in teaching and learning
* Advocacy for the profession
* Innovative clinical practices
* Research
* Leadership
* A commitment from the nominee to attend the induction ceremony at the OADN National Convention in November, if selected.
* One hundred dollar ($100.00) non-refundable nomination fee mailed to:

 OADN

 219 Second Avenue, Suite B

 Edwardsville, IL 62025

(Please, indicate in the memo, or with a note that the payment is related to an AADN application)

For credit card payments, please fill out the following:

 Visa/ MasterCard/ American Express/Discover

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| Credit Card Number:  |
| Expiration Date: CVN # |
| Name on Card:  |
| Billing Address:  |
| City: State: Zip Code:  |

**Deadline to submit: June 4, 2021**

**Return application to:** **Harriet.mcclung@oadn.org**

EM/DM 02/18/20