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**My NL Family Doctor Award**

**Nominee Information Form**

**Your Name:**

**Your Mailing Address:**

**Your Town/City Where You Live:**

**Your Telephone Number:**

**Your Family Doctor’s Name:**

**Your Email Address (if you have one):**

**By nominating my family doctor for this award, I give my permission for the NL College of Family Physicians to use my name, along with the letter written, to recognize my doctor’s work.**

 **Yes**

 **No**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Administrator**

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