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| **Nomination by Institution Form** | | | | | | | | | | | | | | | | |
| ***Chief Nursing Administrator***  *(i.e. the person authorized by the institution to nominate a faculty member for the fellowship award)* | | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | | | | | |  | | |
| Title: | | | |  | | | | | | | | | |  | | |
| Institution: | | | |  | | | | | | | | | |  | | |
| Mailing Address: | | | |  | | | | | | | | | |  | | |
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| E-mail: | | | |  | | | | | | | | | |  | | |
| Phone: | | | |  | | | | | | | | | |  | | |
| Fax: | | | |  | | | | | | | | | |  | | |
|  | | | |  | | | | | | | | | |  | | |
| ***Nomination:*** *I nominate the following faculty member for the fellowship:* | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | | | | | |  | |
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| ***Eligibility:*** *I certify that the nominee meets the following criteria:* | | | | | | | | | | | | | | | |
| 1) | The nominee primarily teaches courses in a pre-licensure registered professional nursing program. “Primarily” means more than 50% of time.  Please specify program: | | | | | | | | | | | | | | |
|  |  | ADN | | | BSN | | Master’s Entry Level | | | | |  |  | | |
| 2) | The nominee teaches in a pre-licensure registered professional nursing program that is   1. Approved by the Illinois Department of Financial and Professional Regulation and 2. Accredited by either the Commission on Collegiate Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing, Inc. (ACEN). | | | | | | | | | | | | | | |
| 3) | The nominee is an Illinois resident (see rules for definition). | | | | | | | | | | | | | | |
| 4) | The nominee is employed as a full-time nursing faculty member. | | | | | | | | | | | | | | |
| 5) | The nominee has been employed at our institution in a teaching position preparing registered nurses for at least 12 months prior to this nomination. | | | | | | | | | | | | | | |
| 6) | The nominee has a *minimum* of a master’s degree in nursing. | | | | | | | | | | | | | | |
| 7) | The nominee has not received this fellowship award in any one of the prior five years (fellows selected in 2020, 2019, and 2018 are not eligible; please note that fellowships were not awarded in 2017 and 2016); | | | | | | | | | | | | | | |
|  | Signature: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  | Date: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| ***Nominee Information****: (i.e., the faculty member I nominated for the fellowship)* | | | | | | | | | | | | | | | |
| Name: | | | |  | | | | | | | | | |  | |
| Mailing Address: | | | |  | | | | | | | | | |  | |
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| E-mail: | | | |  | | | | | | | | | |  | |
| Phone: | | | |  | | | | | | | | | |  | |
| Fax: | | | |  | | | | | | | | | |  | |
| Tenure Status:  (please check ONE) | | | | Tenured | | Tenure-Track | | Non-Tenured | | | No Tenure System | | | |  |
| ***Recommendation:*** Why do you, the Chief Nursing Administrator, believe this faculty member should receive a Nurse Educator Fellowship? Include the nominee’s major accomplishments and any doctorate degrees awarded. | | | | | | | | | | | | | | | |
| *Prepare a separate document and attach to this form. Limit to one page.* | | | | | | | | | | | | | | | |
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