



## MAHCP Member Advocate Nomination Form

*Please print*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Facility: \_\_\_\_\_ Department: \_\_\_\_\_

Area/Site: \_\_\_\_\_

I, \_\_\_\_\_, being a member in good standing with the  
(Nominees Name)

Manitoba Association of Health Care Professionals is hereby eligible to be nominated.

I am aware that the responsibilities of this position require that my contact information will be available to the General Membership and to my Employer.

I accept this nomination: \_\_\_\_\_  
(Nominee's signature)

Nominated by: \_\_\_\_\_ (Please print) \_\_\_\_\_ (Signature)

Seconded by: \_\_\_\_\_ (Please print) \_\_\_\_\_ (Signature)

Nominations can be faxed to **1-204-775-6829** or mailed to:

**Manitoba Association of Health Care Professionals  
101-1500 Notre Dame Ave  
Winnipeg, MB R3E 0P9**

**Closing date for two-year term deadline is May 31st at 1600 hrs.**

**For Office Use only**

Phone #(s): \_\_\_\_\_ E-mail Address: \_\_\_\_\_