HCMA Alliance – Friend of Medicine Nomination Form

Nomination Details: Please complete this form, in addition to downloading and completing the "Become an Alliance Member" form. Then, mail both completed forms with your check to **HCMA Alliance**, 3001 W. Azeele St., Tampa, FL 33609.

* This information is required.

1. Nominating Member's Name* (First and Last)

2. Nominating Member's Email*

3. Nominee's Name* (First and Last)

4. Nominee's Email*

5. Reason for Nomination*

6. Nominee’s Statement*

7. Member's Signature*

8. Date*