

**The Wisconsin Health Care Employee Pride Program  
Submission Form**

Please complete and return this form along with your honored employee's signed application to WHA by **March 26, 2010**. Their story **MUST** be emailed to [snelson@wha.org](mailto:snelson@wha.org) as a Microsoft Word document.

Honored Employee \_\_\_\_\_

Employee's Job Title \_\_\_\_\_

Hospital Name \_\_\_\_\_

Hospital Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Hospital Contact person \_\_\_\_\_

Title \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Fax or email this form **by March 26** to Shannon Nelson at WHA  
Fax: 608-274-8554  
Email: [snelson@wha.org](mailto:snelson@wha.org)