STAR NOMINATION FORM

I wish to nominate

_____ (name)

of _____ (department)

The STAR qualities of my nominee are

S (service) _____

_____

_____

_____

T (team) _____

_____

_____

_____

A (attitude) _____

_____

_____

_____

R (respect) _____

_____

_____

_____

No anonymous nominations will be accepted. The following information is about the nominator.

Nominator's Name _____

☐ Employee ☐ Physician ☐ Volunteer ☐ Patient/Visitor ☐ Other

Address _____

Phone number _____

E-Mail address _____

Date _____

Forms may be mailed or left in drop boxes located in the hospital mailroom or escort information desks.

Mail forms to:

Memorial Hospital
STAR Program
PO Box 1810
Gulfport, MS 39502-1810