### ASPAN Excellence in

### Clinical Practice Award

**2026**

# NOMINATION PACKET

#### To recognize and support excellence in clinical nursing practice in perianesthesia nursing.



## 🙠 Award Criteria 🙢

* A current Active Category member of ASPAN and a component **for the past two full, continuous years** immediately prior to the nomination deadline.
* Registered nurse who is CPAN and/or CAPA certified.
* Registered nurse currently involved in the direct care of perianesthesia patients whose clinical practice is consistent with the standards of ASPAN.
* Minimum five years’ direct care experience in perianesthesia nursing.
* A practitioner whose practice exemplifies a high-level of compassion and specialty expertise documented by peers and/or patients/families as validated by two letters of reference.
* A practitioner who is a recognized expert in clinical nursing practice as shown by their contributions to and support of perianesthesia nursing.
* Participates actively in nursing programs, committees or projects resulting in contributions to perianesthesia nursing.

Contributions and activities used in the evaluation process for the award

must have been completed within the past five years.

## 🙠 Award Description 🙢

*Engraved Crystal Plaque*

*Complimentary registration to the 2027 ASPAN National Conference (non-transferable)*

*Economy airfare to the 2027 National Conference (non-transferable)*

*Host hotel accommodations for four nights at the 2027 National Conference (non-transferable)*

*Announcement in* Breathline

**Nomination Deadline: Postmarked or date-stamped no later than November 30, 2025.**



# ASPAN Excellence in Clinical Practice Award

2026 NOMINATION FORM

**(All information is mandatory)**

|  |  |
| --- | --- |
| **Nominee’s Name and**  **Nursing Degrees / Credentials** |  |
| **Home Address** |  |
| **City / State / Zip Code** |  |
| **Email address** |  |
| **Home Phone**  ***(with area code)*** |  |
| **Work Phone**  ***(with area code)*** |  |
| **Name of Nominee’s Employer, City, State** |  |
| **Nominee’s Position / # of Years** |  |

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|  |  |
| --- | --- |
| **Your Name** |  |
| **Home Address** |  |
| **City / State / Zip Code** |  |
| **Email address** |  |
| **Daytime Phone**  ***(with area code)*** |  |

## Excellence in Clinical Practice Award

NOMINATION CRITERIA

*To qualify, nominees* ***must******meet all*** *of the following criteria.*

*Please answer ‘yes’ or ‘no.’*

Contributions and activities used in the evaluation process for the award

must have been completed within the past FIVE years.

YES\_\_\_ NO\_\_\_ 1. A current Active Category member of ASPAN and a component **for the past two full, continuous years** immediately prior to the nomination deadline of November 30, 2025.

YES\_\_\_ NO\_\_\_ 2. Registered nurse who is CPAN and/or CAPA certified.

YES\_\_\_ NO\_\_\_ 3. Registered nurse currently involved in the direct care of

perianesthesia patients whose clinical practice is consistent with

the standards of ASPAN.

YES\_\_\_ NO\_\_\_ 4. Minimum of five years’ direct care experience in perianesthesia nursing.

YES\_\_\_ NO\_\_\_ 5. A practitioner whose practice exemplifies a high level of

compassion and specialty expertise documented by peers and/or

patients/families as validated by two letters of reference.

YES\_\_\_ NO\_\_\_ 6. A practitioner who is a recognized expert in clinical nursing

practice as shown by their contributions to and support of perianesthesia nursing.

***Instructions for nomination submission:***

1. *Previous Excellence in Clinical Practice Award recipients are* ***not*** *eligible for nomination for a period of three (3) years after winning the award.*
2. *Current members of ASPAN’s Board of Directors are* ***not*** *eligible for nomination.*
3. *All submitted forms must be typed or computer-generated.*
4. *Submit one completed Nomination Form and* ***two (2)*** *Letters of Reference (from two different people – one may be the nominator.)*
5. *Do* ***not*** *send any additional material concerning the nominee with this packet, e.g., copies of newspaper clippings, previous award citations or submissions, etc. Additional material will not be reviewed and will be discarded.*
6. *Nomination deadline is* ***November 30, 2025.*** *Nominations postmarked or date-stamped after November 30 will be returned to sender without review.*
7. *Email required nomination forms to* [*jcerto@aspan.org*](mailto:jcerto@aspan.org) *- or - mail to:*

**ASPAN**

**Excellence in Clinical Practice Award Nominations**

#### **90 Frontage Avenue**

**Cherry Hill, New Jersey 08034-1424**

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*For Office Use Only*

Nominee # \_\_\_\_\_\_\_\_\_\_\_\_\_ ASPAN Mbr #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# ASPAN

### Excellence in Clinical Practice Award

LETTERS OF REFERENCE INSTRUCTIONS

###### Two Letters of Reference

###### Must Accompany The Nomination Form

* Include the nominee’s full name and credentials.
* **Describe why and how your nominee qualifies for the Excellence in Clinical Practice Award by addressing the criteria for nomination.**
* **Letters of reference must be typed, word-processed or computer-generated, and signed by the author.**
* **One of the letters of reference may be from the nominator.**
* **Letter of reference authors must include their name, address, city, state, zip, daytime phone number with area code, preferred email address, employer’s name, position, number of years in position, and if currently an ASPAN member.**
* **Do not send any additional material concerning the nominee with this nomination packet other than what is requested.**
* **Additional material will not be reviewed and will be discarded.**