DUKE UNIVERSITY & HEALTH SYSTEM

BLUE RIBBON AWARD RECOGNITION

TEAMWORK AWARD NOMINATION FORM

Deadline to Submit: Friday, September 11, 2009

Please Type or Print

NOMINATED TEAM NAME:

NOMINATOR: *Dr./Ms./Mr.*

First *Middle Initial* *Last*

Title: Department:

Physical Address: Box:

Phone: Email:

NOMINATED TEAM'S DEPT HEAD AUTHORIZATION

Signature: ____________________ **Name:** *Dr./Ms./Mr.*

First *M. I.* *Last*

Title: Department:

Physical Address: Box:

Phone: Email:

Please check the specific behavior(s) that demonstrates the Nominated Team's commitment to the University Guiding Principle of Teamwork.

- ☐ Works effectively as a part of a team to successfully accomplish a task or goal.
- ☐ Builds effective collaborative relationships across different groups of departments within the organization to define and solve problems or reach agreements on a course of action while considering multiple perspectives.
- ☐ Creates a team environment that promotes communication, trust, cooperation and respect for differences.
- ☐ Contributes to a group effort which has a significant impact on departmental goals.
- ☐ Develops a partnership that seeks input and involvement of those affected by decisions.
- ☐ Accepts responsibility and accountability in helping to advance the University and/or Health System's mission or departmental goal.
- ☐ Places team goals above personal goals while achieving a distinctive result or product.

Please attach a typed summary explaining how the Nominated Team has demonstrated the criteria checked above and why they should be considered for the Teamwork Award. All accepted nominations will be bound and mailed to the nominee with a letter of congratulations.

HELPFUL TIPS:

- Clearly state how the Nominated Team demonstrates a commitment to the University Guiding Principle of Teamwork.
- Cite specific examples of Nominated Team's collaboration efforts, work environment, partnerships with other departments or groups, and accomplishments that are to be commended.
- Describe how the University and/or Health System has benefited from Nominated Team's work.
- **Optional but strongly recommended– Include letters of support for this nomination from additional co-workers, supervisor/manager, and/or department head.**

Completed nominations must be received by 5:00 p.m., Friday, September 11, 2009

Staff and Family Programs, Box 90520, 154 Trent Drive Hall, Fax: (919) 681-8427

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Please Type or Print

NOMINATED TEAM NAME:

TEAM LEADER: *Dr./Ms./Mr.*

First *Middle Initial* *Last*

Title: Department:

Physical Address: Box:

Phone: Email:

Team Leader's Direct Supervisor:

TEAM MEMBER: *Dr./Ms./Mr.*

First *Middle Initial* *Last*

Title: Department:

Email:

TEAM MEMBER: *Dr./Ms./Mr.*

First *Middle Initial* *Last*

Title: Department:

Email:

TEAM MEMBER: *Dr./Ms./Mr.*

First *Middle Initial* *Last*

Title: Department:

Email:

TEAM MEMBER: *Dr./Ms./Mr.*

First *Middle Initial* *Last*

Title: Department:

Email:

TEAM MEMBER: *Dr./Ms./Mr.*

First *Middle Initial* *Last*

Title: Department:

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(Copy this sheet as needed to add more names of team members.)