2019 CBCRP Council Nomination Form

Information About You:

Last Name: ______________________ First Name:___________________ Degree: ________________

Organization or Institution: ____

Address: ____

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Phone: _______________________*Fax:*___ _______________*E-Mail:* ____________________________

What Category Are You Nominating This Person to Fill?:

_____ *Survivor/Advocate* _______*Scientist/Clinician*
_____ *Medical Specialist* _____ *Non-Profit* _______*Private Industry*

Has the Nominee Acknowledged That She/He is Willing to Serve? ________***Yes*** _______ ***No***

Information About Nominee:

Last Name: _____________________ First Name: _____________________ Degree: ______________

Organization or Institution: ____

Address: ____

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Phone Number: ______________________Fax Number: ______________E:Mail: __________________

Please Provide a Brief Description of Nominee's Experience and Expertise:
Experience:

Expertise:

Enclosed Are: _____ Nomination Letter _____ Nominee's Resume/CV

Submit To: Dr. Marion Kavanaugh-Lynch
Director, California Breast Cancer Research Program
University of California
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Oakland, CA 94612-3550
Fax: 510.587-6325 E-mail: CBCRP@ucop.edu