HALL OF HEROES NOMINATION PACKAGE
VA Illiana Health Care System

Purpose:

The purpose of the Hall of Heroes is to recognize military Veterans who receive care or services within the VA Illiana Health Care System who have exhibited exemplary courage in battle or have made outstanding contributions to their communities or professions.

Criteria for Induction:

Category #1: Military accomplishments or significant achievements during a supported Veteran's military career. The nominee must have been awarded one or more of the following U.S. military medals:

- Medal of Honor
- Distinguished Service Cross
- Navy Cross
- Air Force Cross
- Silver Star
- Distinguished Flying Cross of Heroism
- Bronze Star Medal
- Purple Heart
- Any medal with "V" Device

Category #2: For those who have honorably served in the U.S. Armed Forces and then contributed exceptionally to community, state, and/or nation. The nominee must have worn the uniform of our nation's Armed Forces, performed their military duties, received an honorable discharge, and then continued to contribute to community, state, and nation in an exemplary manner.

Process:

Submittals must be complete and submitted to the following address by noon on November 13th to be considered for the current year's inductions. Applications will only be accepted via mail only.

HALL OF HEROES
HSS to the Executive Director(00)
VA Illiana Health Care System 1900 E.
Main Street, Danville, IL
travis.mitchell1@va.gov

Required items in the submittal package include:

- ☐ Hall of Heroes Nomination Form (page 2)
- ☐ Hall of Heroes Verification Form (page 3)
- ☐ Copies of nominee's military awards/citations and DD214 (Nominee MUST have verifiable DD-214)

Hall of Heroes Nomination Form

Date:

Nominated Veteran's Information

Name:

Address:

City:

State:

Zip Code:

Telephone:

Email:

Nomination Package Preparer's Information

Name:

Address:

City:

State:

Zip Code:

Telephone:

Email:

Description of heroism that led to awards or exemplary service to the Veteran's community or profession (attachments allowed):

Hall of Heroes Verification Form

1. I am interested in being considered for induction into the VA Illiana Health Care System Hall of Heroes display. If the Veteran is deceased or unable to sign I, as a legal representative, am submitting this document on behalf of the deserving Veteran.

2. I receive/received my healthcare at the VA Illiana Health Care System or one of its Community Based Outpatient Clinics
   (Bob Michael VA, Mattoon, Decatur, Bloomington, Springfield.)

3. I authorize the required verification of my military records using available sources such as County, State, Federal, and Military records.

4. Citations and decorations need to be verified to ensure fairness to all applicants and families of Veterans.

5. The Hall of Heroes is a public display and may generate media interest. I authorize my contributions to be used in this manner.
   I agree to these guidelines and allow verification of my personal military records.

SIGNATURE: _____

NAME (please print):

Contact Name / Phone / Email if Nominee is Deceased or Incapacitated:

Department of Veterans Affairs

CONSENT FOR PRODUCTION AND USE OF VERBAL OR WRITTEN STATEMENTS, PHOTOGRAPHS, DIGITAL IMAGES, AND/OR VIDEO OR AUDIO RECORDINGS BY VA

NAME OF INDIVIDUAL WHOSE STATEMENT, LIKENESS, OR VOICE IS REQUESTED

NOTE: The execution of this form does not authorize production or use of materials except as specified below. The specified material may be produced and used by VA for authorized purposes identified below, such as education of VA personnel, research activities, or promotional efforts. It may also be disclosed outside VA as permitted by law and as noted below. If the material is part of a VA system of records, it may be disclosed outside VA as stated in the “Routine Uses” in the "VA Privacy Act Systems of Records" published in the Federal Register.

The purpose of this form is to document your consent to the Department of Veterans Affairs' (VA) request to obtain, produce, and/or use a verbal or written statement or a photograph, digital image, and/or video or audio recording containing your likeness or voice. By signing this form, you are authorizing the production or use only as specified below.

You are NOT REQUIRED TO CONSENT TO VA's REQUEST to obtain, produce, and/or use your statement, likeness, or voice. Your decision to consent or refuse will not affect your access to any present or future VA benefits for which you are eligible.

You may rescind your consent at any time prior to or during production of a photograph, digital image, or video or audio recording, or before or during your provision of a verbal or written statement. You may rescind your consent after production is complete if the burden on VA of complying with that request is not unreasonable considering the financial and administrative costs, the ease of compliance that number of parties involved, and N/A *(To Be Completed by the VA).*

THE PHOTOGRAPH, DIGITAL IMAGE, AND/OR VIDEO OR AUDIO RECORDING WILL BE PRODUCED WHILE I AM *(describe the activity or situation)* ***(To Be Completed by the Department of Veteran Affairs, if applicable)***

I am submitting my photo(s) and/or video to VA Illiana for use on digital and traditional media outlets as part of activities, events, displays, or celebrations associated to VA Illiana's Hall of Heroes initiative.

CHECK AT LEAST ONE OF THE FOLLOWING ***(to be completed by VA)***

☒ I hereby voluntarily and without compensation authorize VA Illiana Healthcare System
NAME OF FACILITY

to produce a photograph, digital image, and/or video or audio recording of me *(or of the above named individual if the individual is legally unable to give consent).*

☒ I hereby voluntarily and without compensation authorize VA Illiana Healthcare System
NAME OF FACILITY

to obtain or use a verbal or written statement from me *(or the of the above named individual if the individual is legally unable to give consent).*

I consent to allowing VA to record and use a verbal or written statement, or produce and use photographs, digital images, and video or audio recording for the purpose(s) identified below:

This product will be used: *(NOTE: At least one of these boxes must be checked as well as a purpose described below) (to be completed by VA)*

☒ Internally *(stay within VA)* ☒ Externally *(shared outside VA)*

PLEASE CHECK THE APPLICABLE PURPOSE(S) ***(to be completed by VA)***

PROMOTIONAL EFFORTS:

☐ Internal Publication *(only VA)* ☐ External publication *(publicly available)*

☐ Other *(Specify)*:

RESEARCH ACTIVITIES: ☐ Study

EDUCATION PURPOSES:

☐ Presentation ☐ Conference ☐ Publication in a Journal ☐ Training

☐ Other *(Specify)*:

VA ONLY USE:

☐ Performance Improvement ☐ Quality Improvement ☐ Health Care Operations

☐ Other *(Specify)*:

☒ All of the Above

NOTE: Do not sign this form unless one or more of the boxes above has been checked.

I have read and understand the foregoing, and I consent to the use of a verbal or written statement from me, and/or of my likeness and/or voice as specified for the above-described purpose(s). I understand that no royalty, fee, or other compensation of any kind will be made to me by the United States for such use. I understand that consent to obtain, produce, and/or use a verbal or written statement, photograph, digital image, and video or audio recording containing my likeness or voice is voluntary, and my refusal will not adversely affect my access to any present or future VA benefits for which I am eligible. I further understand that I may, at any time, rescind my consent prior to or during production of a photograph, digital image, or video or audio recording. I also understand that I may rescind my consent after production is complete if the burden on VA of complying with that request is not unreasonable considering the financial and administrative costs, the ease of compliance, and the number of parties involved.

PRINT FULL NAME *(First and Last Name)*	SIGNATURE	DATE *(MM/DD/YYYY)*

PERMISSION OBTAINED BY ***(TO BE COMPLETED BY VA)***

PRINT EMPLOYEE FULL NAME	TITLE	DATE *(MM/DD/YYYY)*

SIGNATURE OF PERSON OBTAINED OBTAINING CONSENT ***(TO BE COMPLETED BY VA)***

PRINT EMPLOYEE FULL NAME	SIGNATURE	DATE *(MM/DD/YYYY)*

IMPORTANT: If VA is providing or releasing any patient health or demographic information with the verbal or written statement, photograph, digital image, or video or audio recording, VA Form 10-5345, Request for and Authorization to Release Medical Records or Health Information, is required prior to the release of such data to any source outside VA.