

 

**Application Form**

**International Women’s Health Care Policy Course**

Applying for the course in **YEAR**

**Student ID# (if applicable):**

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| Last Name:  |       | First Name: |       | Middle: |       |
| If you have educational records under a different name, give former name(s):       |
| Home Phone: |       | Cellular Phone: |       |
| E-mail Address: |       |  |
| Mailing Address: Street: |       | Apt. #: |       |
| City:       | State: |       | Zip Code:      | Country : |       |
| Emergency Contact: Name: |       | Phone #: |       |
| Street: |       | City: |       | State & Zip Code: |       |

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| Status: | Choose an item. | Other: specify visa category (F-1, H-1, etc.) |       |
| Passport #:       | Date & Place of Issue: |       |
| If you are not a U.S. citizen, indicate country of origin: |       |
| Length of Residence in New York State (Years) |       | Sex: | Choose an item. |
| Place of Birth: |       | Date of Birth |       |
| If you wish to identify yourself as a member of an ethnic/racial group,  | Choose an item. |

## State University of New York Downstate Medical Center

450 Clarkson Avenue, Box 1227, Brooklyn, NY 11203-2098 • Tel. 718-270-7740/41 Fax 718-270-7634

web: http://www.downstate.edu/CHRP/midwifery/index.html

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| **From what source were you made aware of this course?** | Choose an item. |

**In approxiamtely 500 words explain your interest in the host country’s health policy and your plans for the application of knowledge acquired by enrolling in the course.**

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| List any honors you have received:       |
| List professional organization memberships:      |
| List any community activities in which you have participated:       |
| Except for minor traffic violations, were you ever convicted of any violation of the law? Choose an item.If yes, please attach a page with an explanation. |

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| I certify that the information here is complete and correct to the best of my knowledge. |
| Signature: | Date: Click here to enter a date. |