APPLICATION FORM
for
The Maternal-Infant-Matrix (MIM) Storyboard Methodology Practicum Training

Sponsored by:
The Rollins School of Public Health at Emory
Atlanta, Georgia USA

Please type or print clearly and mail/e-mail/fax application to:

Pia Valeriano, MBA
Hubert Department of Global Health, Rollins School of Public Health at Emory University
1518 Clifton Road, NE, CNR Bldg., 7th floor
Atlanta, GA 30322; Phone: 404-727-3485 Fax: 404-727-4590; Email: pvaleri@sph.emory.edu

☐ Mr. ☐ Ms. ☐ Dr.

First Name: __________________________________ Last (family) Name: ________________________

Complete Mailing Address: __________________________________________________________________

City___________________________________ Country________________________________________ Zip Code________

Work Telephone: ________________________ Work Fax: ________________________________

Email Address: __________________________ Supervisor’s Email/Phone: ______________________

Employer: ______________________________________________________________________________

Employer Complete Mailing Address: ________________________________________________________

City___________________________________ Country________________________________________ Zip Code________

Title/Position: __________________________________________________________________________

Education (degrees & dates): _________________________________________________________________

________________________________________________________________________________________

Previous Experience in Health, Public Health, Epidemiology, Statistics or Laboratory Science:

________________________________________________________________________________________

________________________________________________________________________________________
Current Responsibilities: 

___________________________________________________________________

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___________________________________________________________________

Please indicate how your training will be financed:

☐ Self       ☐ Employer       ☐ Other Organization:

________________________________________

Contact Person for billing Purpose: __________________________________________

Address: __________________________________________

__________________________________________________________________________

Phone: ___________________  Fax: ___________________  Email: ___________________