Print Form

POLHN
Improving Pacific Healthcare Through eLearning

STUDENT APPLICATION FORM
Pacific Open Learning Health Network. Please return and fax to:
World Health Organization (Fax: 679 323 4144)

DO NOT WRITE IN THE BLOCK – FOR WHO OFFICE ONLY

Course Category
☐ Self-paced
☐ Instructor-Led

Semester:
Year:

Country Coordinator's Name: _____

Country Coordinator's Signature: _____

Date:_____ Application was filed on: _____

Comments:_____

_____

A. Course Information

1. Which course are you applying for? HINARI - Health InterNetwork Access to Resea

2. Semester: 2 Year: 2012

B. Information about you

Status: Dr Other: Sex: Female

1.Family Name (in CAPS) (Given Names)

2. Residential Address:

Street: Town or City: Country:

Postal Address if different from above:

3. Date of Birth

Day: 31 Month: December Year:

4. Other Names used (including maiden name)

5. Citizenship:

6. Email Address:

C. Work & Study Information

1. Are you working?: No If yes, state occupation.

2. Workplace (name of hospital / health centre, etc)

2. Are you currently studying? No If yes, give details of course, Level and institution.

D. Other information

3. Knowledge of English: ☐ Basic ☐ Fluent ☐ Excellent

4. Knowledge of IT: ☐ Basic ☐ Good ☐ Excellent

5. Highest level of study: ☐ Technical/Vocational ☐ Undergraduate ☐ Postgraduate

6. Previous work experience

7. Describe your area of specialization, interest and capabilities that would in your opinion contribute to classroom discussions.

8. Expectations: What do you hope to get out of the course?

9. Which modules are most relevant to your work? Which order would you like to do the modules?

10. Current problems that you face in your organization relating to your work?

11. Time allocation: Time that you will allocate to the course (1) at work (2) personal time

E. Signature of applicant

I declare that the information contained on this form and all my correspondence is correct in every detail.

Date: (DD/MM/YY) Phone Number: ( )

F. Support from Department

Name of Head of Section/Supervisors

Signature
Date: (DD/MM/YY)

G. Endorsement of Ministry of Health

Ministry of Health

Signature
Date: (DD/MM/YY)

[-E-N-D-S-]