Boston Children's Hospital and Department of Social Medicine, Harvard Medical School International Child Mental Health Training Program

Application Form

Name Last _____ First _____

Address _____

Telephone _____ email _____

School Affiliation _____

Position in School (Year of schooling, level of schooling, pre-medical, medical, other)

_____

Age _____

Visa Status (U.S. student visa required) _____

Reason for special interest in child mental health?

_____

Prior mental health training/education experience:

_____

Have you read the program description? ☐ Yes ☐ No

Do you understand that the program requires you to pay a tuition according to the length of the program you make application for? ☐ Yes ☐ No

Do you have the financial resources available? ☐ Yes ☐ No

What is the source?

_____

Do you understand that for whatever reason you may choose to leave the program that the fees will not be able to be reimbursed, and that the appropriate authorities will be notified in relation to your visa status? ☐ Yes ☐ No

I understand that this is an application to the International Child Mental Health Training Program of the Boston Children's Hospital and the Harvard Department of Psychiatry and that the completion of this application does not entitle me to admission. I will be notified in writing of the decision about admitting to the program after the application has been received and processed.

Name _____ Date _____

Please return via email to Myron_Belfer@hms.harvard.edu