**Application to Join the Roma Health Network**

*Thank you for your interest in becoming a member of the Roma Health Network. Please complete the form below, indicating your answers to the following questions:*

- Your organisation agrees with the [**Terms of Reference of the Roma Health Network**](https://epha.org/wp-content/uploads/2020/06/roma-health-network-terms-of-reference-final.pdf), organised under the auspices of the European Commission's Health Policy Platform

- Your organisation consents to the data of its named representative (completed below) to be managed by the European Public Health Alliance (EPHA), for the purpose of communications regarding the Roma Health Network

***On completing the form below, your details will be added to the Roma Health Network mailing list if your individual or organisation's application is successful.***

Communication preferences can be updated at any time by contacting **nicoleta.diaconu@epha.org** or following any communication you receive regarding the network.

Please send a **one-page** **outline** explaining your organisation's **motivation** to join the network to **tomas.dejong@epha.org**.

If you wish to join as an **individual**, please send a copy of your **CV** to the same e-mail address.

Please also send any questions you may have about the network or the process to the same email address.

**Please fill out the following table with the requested information.**

|  |
| --- |
| **Email Address:** |
| **First Name:** |
| **Surname:** |
| **Job Title:** |
| **Organisation:** |
| *I am joining:** *On behalf of an* ***organisation***
* *As an* ***individual***
 |

*If accepted, your application will be sent to the Roma Health Network Members who will have* ***7 days*** *to voice their objections. If there are no objections, you will be approved and added to the mailing list, as mentioned above.*