



**PROGRAM IN APPLIED
PUBLIC HEALTH SCIENCES**

Photo Directory Consent and Release Form

I, the undersigned, give the University of Connecticut Department of Public Health Sciences and the Program in Applied Public Health Sciences permission, now and in the future, to use any information I give below, along with my photo for any Program in Applied Public Health Sciences activities, including the Public Health Photo Directory.

Signature

Name (please print)

Current Job and Place of Employment (please print)

Contact Email Address (please print)

Date

I wish the following information to be **excluded** in the Public Health Student Directory

- Photo
- Name
- Email
- Current Employment and Job