AMERICAN HOSPITAL

APPLICATION FORM IN ACCORDANCE WITH THE PROTECTION OF PERSONAL DATA LAW

A. Contact details of the applicant data owner:

Name Surname	:	.....
Date of Birth and TR ID No	:	..... / ..... / ....
Phone Number	:	.....
E-mail Address	:	.....
Address	:	.....

B. Contact information of the authorized person applying on behalf of the data owner:

(This section will be filled if the data owner is different from the applicant)

Name Surname	:	.....
Date of Birth and TR ID No	:	..... / ..... / ....
Phone Number	:	.....
E-mail Address	:	.....
Address	:	.....

C. Please state your relationship with American Hospital.

(Such as "patient, former employee, third party, firm employee")

To be filled by those receiving health services from American Hospital

☐ Ambulatory Treatment ☐ In-Patient Treatment	☐ Operation ☐ Other: ……..
Units Provided Health Services: ……...……..……..…….....	

To be filled by the employees of American Hospital

☐ Currently Employed ☐ Former Employee *Years of employment:* ..... ☐ Other:	☐ I made Job Application / I shared my CV *Date:* ..... ☐ I'm a Third Party Employee *Please state the company and position information* .....

Form no: 1000.037 Rev. no: 00

D. Please provide details of your application about your demands under the Protection of Personal Data Law:

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E. Please select the method by which you will be notified to your application:

- ☐ I want it to be sent to my address.
- ☐ I want it to be sent to my e-mail address.
- ☐ I want it to be delivered by hand.
  (In case of representation via proxy, it is necessary to have a power of attorney or a certificate indicating the authority of authorized person.)

F. Statement

Please kindly be informed that you can fill in this form and send via notary or personally submit a signed copy to the address Güzelbahçe Sok. No: 20 Zip Code: 34365 Nişantaşı, İstanbul, Turkey or send it to **momentegitimarastirma@hs02.kep.tr** via e-mail with your secured electronic signature. This application form is prepared to provide an accurate and complete response to your request relating to your personal data, if any, processed by American Hospital within the legal timeframe by identifying your relationship with the Amerikan Hospital. American Hospital reserves the right to request additional documents and information (identification card or driver's license, etc.) for identification and authorization purposes, in order to eliminate legal risks that may arise from unlawful and unfair data sharing and in particular to ensure the safety of your personal data. In the event that the information you are submitting under this form are not up-to-date or correct or the application is unauthorized, American Hospital does not accept responsibility for claims arising out of or in connection with such incorrect or unauthorized information and also for the inconvenience which may occur in the process of responding to the addresses declared by you.

Application date: ..... / ..... / .....

Name and Surname of the Applicant: ..... **Signature:** .....

To be filled by the hospital

Date: ..... / ..... / .....

Name Surname of the Recipient: ..... **Signature:** .....