DATA SUBJECT ACCESS REQUEST FORM REQUEST FORM ACCORDING TO THE PERSONAL DATA PROTECTION LAW

You may convey your requests regarding your rights specified under Article 11 of the Personal Data Protection Law no. 6698 ("**Law**") to Halikarnas Özel Sağlık Hizmetleri ve Sağlık Malzemeleri Sanayi ve Ticaret Anonim Şirketi ("**Hospital**") with one of the methods described below in accordance with Article 13 of the Law and Article 5 of the Communiqué on the Principles and Procedures for Request to the Data Controller with this form.

	REQUEST METHOD	ADDRESS TO MAKE REQUEST	INFORMATION TO BE SHOWED ON THE REQUEST
1. Request in writing	In person request with wet signed, via notary or cargo/mail	Türkkuyusu Mahallesi, Marsmabedi Cad 33/35, 48400 Bodrum/MUĞLA	"Information Request Within the Scope of the Personal Data Protection Law" will be written on the envelope / notification.
2. Request via registered electronic mail (KEP)	via registered electronic mail (KEP) address	halikarnassaglık@hs02.kep.tr	"Personal Data Protection Law Information Request" will be written on the subject of the e-mail.
3. Request via E-mail Address registered in the System of Our Hospital	via e-mail address registered in the system of our Hospital	kisiselveri@bodrumamerikanhastanesi.org	"Personal Data Protection Law Information Request" will be written on the subject of the e-mail.
4. Request via E-mail Address which is not registered in the System of Our Hospital	via e-mail address which is not registered in the system of our Hospital, **including mobile signature / e-signature.**	kisiselveri@bodrumamerikanhastanesi.org	"Personal Data Protection Law Information Request" will be written on the subject of the e-mail.

A. Identity and contact information of the data subject who made the request

Please fill in the fields below in order for us to contact you and verify your identity.

Name Surname : .....

Date of Birth and Gender : ..... / ..... / ....

TC ID No : .....

Nationality for Foreigners : .....

Passport number for Foreigners : .....

Identity number, if available, for Foreigners : .....

Telephone No – Fax No (if any) : ....

E-mail address : .....

Address : .....

B. Contact information of the authorized person who made the request on behalf of the data subject:
(This section will be filled in if the data subject and the person who made the request are different.)

Name Surname	**:**.....
Date of Birth and Gender	**:** ..... / ..... / ....
TC ID No	**:** .....
Nationality for Foreigners	**:** .....
Passport number for Foreigners	**:** .....
Identity number, if available, for Foreigners	**:** .....
Telephone No – Fax No (if any)	**:** ....
E-mail address	**:** .....
Address	**:** .....

C. Please indicate your relation with the Hospital.
(Such as "patient, ex-employee, employee, other (please specify)")

Hospital employees will fill in

☐ Current employee ☐ Ex-employee *Years worked:* ..... ☐ Other:	☐ I made a Job Application / I shared my CV *Date:* ..... ☐ Other: ..... *Please indicate the company you work at and your position* .....

D. Subject of Demand:

We kindly request you to clearly write your demand regarding your personal data below. Information and documents related to the subject should be attached to the request.

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E. Please select the notification method of our reply to your request:

- ☐ I would like the reply to be sent to my mailing address, which I specified in the A / B section.
- ☐ I would like the reply to be sent to my e-mail address, which I specified in the A / B section.
- ☐ I would like the reply to be sent to fax number, which I specified in the A / B section.
- ☐ I would like to receive by hand (In case of receiving by proxy, power of attorney or a document showing the authority of the authorized person must be present).

To be filled in by the Person who made the Request

In line with my abovementioned demands, I kindly ask you to evaluate the request that I made to your Hospital in accordance with Article 13 of the Law and to inform me on this subject. I hereby declare that my information and documents that I have provided to you in this request are correct and up-to-date and I have been informed that your Hospital may request additional information in order to finalize my request and that if a cost is required, I may have to pay a fee according to the tariff determined by the Personal Data Protection Board.

Date of Request: ..... / ..... / .....

Name Surname
of the person who made the request: ..... **Signature:** .....

To be filled by the Hospital

This request form that you have filled out has been prepared to determine your relation with the Hospital, if any, and to respond to your concerning request regarding your personal data processed by the Hospital accurately and within the legal period. Hospital may request additional documents and information (copy of the identity card or driver's license, etc.) for identification and authorization check in order to eliminate the legal risks that may arise from unlawful and unfair data transfer and especially to ensure the security of your personal data.

Date of Request: ..... / ..... / .....

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