PATIENT'S / LEGAL GUARDIAN'S STATEMENT

PLEASE FILL IN USING CAPITAL LETTERS AND MARK WITH 'X' IN SUITABLE SQUARES

ALERGO-MED AVIATION

Patient's data:

....
First name and last name *PESEL number / passport number*

....
Father's name *Mother's name*

.....
Address

....
Phone number *E-mail address*

<u>If the patient is underage, the legal guardian completes the statement and his/her data should be provided:</u>

....
First and last name of the parent / legal guardian *PESEL of the parent / guardian*

....
First and last name of the other parent / legal guardian *PESEL of the other parent / guardian*

! ☐ **I authorize the examination / provision of health services in this facility.**

Consent to the examination / provision of the benefit is valid u ntil its cancellation (pursuant to Article 14 (2) (3) and Artic le 26 paragraph 1 of the Act of November 6, 2008 on patient rights an d the Ombudsman for Patient Rights (Journal of Laws 2016.186, i .e. from 2016.02.16).

☐ I do not authorize anyone to obtain information about the patient's health

1.
☐ I authorize to obtain information on the state of health

....
First and last name of the authorized person

....
PESEL / Passport number *Phone number*

2.
☐ I authorize to obtain information on the state of health

....
First and last name of the second authorized person

....
PESEL / Passport number *Phone number*

☐ I do not authorize anyone to obtain patient's medical records

I authorize to obtain medical documentation in all legally permissible forms:

1.
☐ I authorize to obtain medical records

....
First and last name of the authorized person

....
PESEL *Phone number*

2.
☐ I authorize to obtain medical records

....
First and last name of the second authorized person

....
PESEL *Phone number*

Legal basis: Regulation of the Minister of Health of 9 November 2015 on the types, scope and templates of medical documentation and how to process it (Journal of Laws 2015, item 2069).

.....
Date and signature of the patient / legal guardian

!

Today, before my aviation and/or occupational medicine examinations, I declare that:

1. I am rested, I feel healthy and ready to undergo examinations, and for the last 24 hours I have not consumed alcohol and cared for rational nutrition. I put myself on an empty stomach for tests. I am not on sick leave.

2. I have read carefully the statements regarding my state of health and medical history included in the Application Form for the Medical Certificate, and the data I complete are, to the best of my knowledge, true and complete. I did not conceal any relevant information and did not put any misleading statements. I understand that providing incomplete or false data in the Form may result in a negative medical certificate issued by a certifying physician or an authority entitled to licensing may refuse to issue a decision or withdraw all issued decisions aviation medical notifications in addition to all other operations applicable under national law.

3. I have been informed that pursuant to art. 106 section 3 of the Act of 3 July 2002 - Aviation Law (Journal of Laws of 2019, Pos. 1580 and 1495) I have the right to appeal against a medical certificate issued by a doctor aero-medical certificate to the Chief Civil Aviation Doctor within 14 days of receipt judgment. Appeals against medical certificates are submitted to the Chief Civil Aviation Doctor through the certifying doctor by whom it was issued.

! ☐ **I agree to send the results of laboratory tests to the email address indicated by me on page 1 of this statements (for contacting the patient or guardian). I declare that when agreeing to the message I have been informed of the results of the research via electronic means of communication sending data electronically and I take full responsibility for the circulation and security of the shared data.**

In accordance with Regulation (EU) 2016/976 of the European Parliament and of the Council of 27 April 2016 on the protection of persons in connection with the processing of personal data and on the free movement of such data and repealing the Directive 95/46 / EC (General Data Protection Regulation), I consent to the processing of my personal data in this facility for the needs of:

! ☐ **Contact via phone call / text messages for the purpose of the visit (regarding confirmation, postponement, cancellation)**

Providing contact details is voluntary, however, failure to consent will result in the inability to notify the patient / authorized person about critical test results and / or provide other relevant information.

Information clause

The administrator of personal data provided in this statement for the purposes of providing services medical is Romana Borkowska running a business under the name ALERGO-MED Poradnia Specjalistyczna. Personal data will be processed in connection with:

- contact with authorized persons indicated by the Patient (consent is voluntary);
- contacting the patient or the patient's legal guardian by phone, sms or e-mail (consent is voluntary);
- granted consent to send results of laboratory / diagnostic tests electronically (consent is voluntary);
- granted consent to send marketing communications and to process data for marketing purposes (consent is voluntary).

In all matters related to the processing of personal data, you can contact the Data Protection Officer at address: iod@alergo-med.com.
The personal data obtained may be transferred to other entities in specific cases in the information obligation arising from art. 13 GDPR, which is available on information boards in ALERGO-MED clinics and on the clinic's websites (alergo-med.com and badanialotniczolekarskie.pl).

! ☐ **I have been informed about the right to access the content of the above data and the right to correct, update, topping up and deleting. I have read the information obligation arising from art. 13 GDPR.**

.....
Date and signature of the patient / legal guardian

!