

CSL Data Subject Request Form – Representative

Please answer all of the following questions completely and truthfully.

Enter the date you are making this request [Day/Month/Year]	
Information about you	
Enter your first name.	
Enter your surname.	
Enter your phone number. (Please include the country code)	
Enter your postal address. Address must include: Street Address Village/Town/City County Postcode Country	
Enter your e-mail address.	
Can we contact you by e-mail regarding this request?	<input type="checkbox"/> Yes - This is how we will contact you and provide any information regarding your request. <input type="checkbox"/> No - How would you prefer us to contact you and provide any information regarding this request? <input type="checkbox"/> Post <input type="checkbox"/> Phone <input type="checkbox"/> Other (please specify):
Can you provide proof of identification?	<input type="checkbox"/> Yes - Please attach a copy of your identification (e.g. photo ID, passport, or another proof of identification). <input type="checkbox"/> No - Please provide an explanation. Please note that your request may be delayed until verification of your identity has been obtained.

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Information about the person for whom you are requesting information	
Enter the first name of the person for whom you are requesting information.	
Enter the surname of the person for whom you are requesting information.	
Enter any former/alternative name(s) of the person for whom you are requesting information.	
What is your relationship to the person for whom you are requesting information?	<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian or Representative <input type="checkbox"/> Immediate Family Member (e.g. child or sibling) <input type="checkbox"/> Other (please enter brief description)
If you are the parent, please provide your child's date of birth [Day/Month/Year].	
Enter the phone number of the person for whom you are requesting information.	<input type="checkbox"/> Tick here if you are unable to provide the person's phone number.
Enter the postal address of the person for whom you are requesting information. Address must include: Street Address Village/Town/City County Postcode Country	<input type="checkbox"/> Tick here if you are unable to provide the person's postal address.
Enter the e-mail address of the person for whom you are requesting information.	<input type="checkbox"/> Tick here if you are unable to provide the person's e-mail address.
Can you provide proof of your relationship with the person for whom you are requesting information?	<input type="checkbox"/> Yes - Please attach proof of your relationship (e.g. birth certificate, power of attorney, written verification signed by the person with an accompanying photo ID). <input type="checkbox"/> No - Please provide an explanation. Please note that your request may be delayed until verification of your relationship has been obtained.

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<p>Has the person for whom you are requesting information asked or authorised you to make this request on their behalf?</p>	<p><input type="checkbox"/> Yes - Please attach proof of the authorisation (i.e. written authorisation signed by the person with an accompanying photo ID).</p> <p><input type="checkbox"/> No - Please provide an explanation. Please note that your request may be delayed until verification of your authorisation to make this request has been obtained.</p>
<p>Can we contact the person for whom you are requesting this information to verify this request?</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No - Please provide an explanation. Please note that your request may be delayed.</p>
<p>For which CSL entity are you requesting information? (Select one)</p>	<p><input type="checkbox"/> CSL Behring</p> <p><input type="checkbox"/> CSL Plasma</p> <p><input type="checkbox"/> Seqirus</p>
<p>What is the relationship with the CSL entity? (Select one)</p>	<p><input type="checkbox"/> Patient/Donor or Customer</p> <p><input type="checkbox"/> Health Care Providers (HCPs) who are not clinical trial investigators</p> <p><input type="checkbox"/> Clinical Trial Investigator (e.g. nurses, site coordinators, investigators)</p> <p><input type="checkbox"/> Clinical Trial Participant (e.g. patients in a clinical trial)</p> <p><input type="checkbox"/> Family (e.g. HCP spouses, employee dependents, patient caregivers)</p> <p><input type="checkbox"/> Current Employee</p> <p><input type="checkbox"/> Former Employee</p> <p><input type="checkbox"/> Candidates for Employment</p> <p><input type="checkbox"/> Contractor or Contingent worker</p> <p><input type="checkbox"/> Third party vendor/supplier</p> <p><input type="checkbox"/> Other (please enter brief explanation):</p> <hr/>

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<p>Provide a unique CSL Identifier to help us locate your data. (Select one)</p>	<p><input type="checkbox"/> Patient/Donor ID (please specify): _____</p> <p><input type="checkbox"/> Health Care Provider (HCPs) Number (please specify): _____</p> <p><input type="checkbox"/> Clinical Trial Investigator ID (please specify): _____</p> <p><input type="checkbox"/> Clinical Trial Subject ID (please specify): _____</p> <p><input type="checkbox"/> Employee ID (please specify): _____</p> <p><input type="checkbox"/> Applicant Number (please specify): _____</p> <p><input type="checkbox"/> Contractor or Contingent worker User ID (please specify): _____</p> <p><input type="checkbox"/> Third party vendor/supplier Number (please specify): _____</p> <p><input type="checkbox"/> Other (please specify): _____</p> <p>What type of identifier is this? _____</p> <p><input type="checkbox"/> I do not have a unique CSL Identifier</p>
<p>Information about the request</p>	

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<p>What type of request are you making? (Select one)</p>	<ul style="list-style-type: none"><input type="checkbox"/> Access: request for further details regarding how CSL makes use of Personal Data and a copy of the Personal Data that CSL holds <input type="checkbox"/> Rectification: request for CSL to correct specific Personal Data that it is processing if it is inaccurate or incomplete Note: In your response to the following question, please provide detail on how the data is currently recorded/listed as well as how the person for whom you are requesting would like data to be changed <input type="checkbox"/> Erasure: request for CSL to delete or remove specific Personal Data that is no longer needed for a legal or legitimate purpose <input type="checkbox"/> Portability: request for CSL to move, copy or transfer Personal Data to another organisation in a secure and usable manner <input type="checkbox"/> Objection/Restriction of Processing of Personal Data: request for CSL to stop processing specific Personal Data, either entirely, for a limited time or for certain purposes <input type="checkbox"/> Objection to Automated Decision-Making: request for CSL to cease making automated decisions and review any decision made
<p>Enter a clear description of what action you are seeking.</p>	

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<p>What type(s) of data is this request regarding? (Select all that apply)</p>	<p><input type="checkbox"/> General Contact Information (e.g. Name & Initials, Personal Directory Information such as e-mail, address and phone number) (please specify): _____</p> <p><input type="checkbox"/> Personal Information (e.g. Personal characteristics such as racial or ethnic origin, age, place of birth, gender identity, religious or philosophical belief and sexual orientation, Household information such as estimated income, number of cars owned, dwelling type, Sensitive Personal Data such as criminal records, account usernames) (please specify): _____</p> <p><input type="checkbox"/> Personal Identification Information (e.g. Government Issued Identification such as driving licence, passport number, national identity card) (please specify): _____</p> <p><input type="checkbox"/> Digital Information (e.g. account login information, Cookie Identifiers)</p> <p><input type="checkbox"/> Health Information (e.g. medical history, genetic information, visit history, insurance, information, adverse reactions to medications) (please specify): _____</p> <p><input type="checkbox"/> Employment Information (e.g. occupation, compensation, performance reviews) (please specify): _____</p> <p><input type="checkbox"/> Education and Professional Qualification Information (e.g. education history, academic record, professional identifiers) (please specify): _____</p> <p><input type="checkbox"/> Family/Caregiver information (e.g. information related to dependents such as the name, age and/or gender of a child or caregiver) (please specify): _____</p> <p><input type="checkbox"/> Financial Information (e.g. credit card information, financial transactions, credit history) (please specify): _____</p> <p><input type="checkbox"/> Clinical Trial Information (e.g. study information, treatments provided as part of a study, patient outcome, treatment dates) (please specify): _____</p>
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	<input type="checkbox"/> Financial Reporting Information (e.g. Financial statements, Customer Pricing) (please specify): <hr/>
	<input type="checkbox"/> Other (please enter a brief description): <hr/>
Is there a specific CSL system or application you would like us to search to evaluate your request?	<input type="checkbox"/> Yes (please specify): <hr/> <input type="checkbox"/> No

By ticking this box, I certify that I understand that before complying with this request, CSL may require me to provide:

- a. Proof of my identity;
- b. Proof of the identity of the individual for whom I am making the request and further proof of my status as a relevant person; and
- c. Such further information as may be reasonably required for CSL to complete the request.

I understand that missing or incomplete information may result in a rejection of the request or a delay in the completion of the request.

Printed Name

Signature

Except with the prescribed consent of the individual concerned, the Personal Data provided in this form will be used only for the purposes of processing this request and other directly related purposes. All information collected as a function of this request will be deleted 120 calendar days after the request has been closed, unless required for continuing legal requirements.