CANADIAN THALIDOMIDE SURVIVORS SUPPORT PROGRAM
Consent to Communicate Information to a Representative

This form allows you to name a person as your representative to communicate with the Canadian Thalidomide Survivors Support Program Administrator, on your behalf. It also allows the Canadian Thalidomide Survivors Support Program Administrator to communicate to your representative your personal information, including but not limited to, the details of your application(s)/file with Canadian Thalidomide Survivors Support Program Administrator.

Section 1: Your Consent (to be completed by the Thalidomide survivor/claimant/legally authorized representative)

Thalidomide survivor/claimant/legally authorized representative information:

First Name(s)	Middle Name(s)	Last Name(s)
(PO Box, Street No., Apt., RR)		City/Town/Community
Province/Territory/State	Postal/Zip Code	Date of Birth (mm/dd/yyyy)

I give consent for employees of the Canadian Thalidomide Survivors Support Program Administrator to communicate with my representative named in Section 2 any information, including personal information, relating to my application(s)/file with the Canadian Thalidomide Survivors Support Program Administrator. I understand **this consent remains valid for 2 years from the date I signed it unless I cancel it in writing prior to that time**. I also understand that by signing this form I am giving my representative the authority to give and receive information on my behalf. I am not, however, giving my representative the authority to make decisions or to take action(s)/make any transaction(s) on my behalf.

Your Signature	Date: mm/dd/yyyy

Signature with a Mark

If the Thalidomide survivor/claimant/legally authorized representative signed with a mark (for example “X”), the mark must be in the presence of a witness. A witness may be a relative. The witness must provide the following information:

Witness First Name(s)	Witness Initial(s)	Witness Last Name(s)
Witness (PO Box, Street No., Apt., RR)		Witness City/Town/Community
Witness Province/Territory/State		Witness Postal/Zip Code

Relationship to Thalidomide survivor/claimant/legally authorized representative

If the Thalidomide survivor/claimant/legally authorized representative signed with a mark, the witness must also sign the following declaration: I have read the content of this consent form to the Thalidomide survivor/claimant/legally authorized representative who understands and confirms the complete contents and who made his or her mark in my presence.

Signature of Witness | Date: mm/dd/yyyy

Section 2: Your personal representative (to be completed by representative)

Personal Representative's Information:

First Name(s) | Middle Name(s) | Last Name(s)

(PO Box, Street No., Apt., RR) | City/Town/Community

Province/Territory/State | Postal/Zip Code | Date of Birth (mm/dd/yyyy)

Home Phone Number | Work Phone Number | Cell Phone Number

Relationship to Thalidomide survivor/claimant/legally authorized representative

I understand that I can communicate with employees of the Canadian Thalidomide Survivors Support Program Administrator to give and receive information on behalf of the person named in Section 1, in relation to that person's application(s)/file with the Canadian Thalidomide Survivors Support Program Administrator. I also understand that I do not have authority to make any decision(s) or to take action(s)/make any transaction(s) on this person's behalf.

Your Signature | Date: mm/dd/yyyy

Protection of your personal information

The information requested in this Consent to Communicate Information to a Representative form is being collected, used and retained by the Canadian Thalidomide Survivors Support Program Administrator and its Agents for the purpose of operating and administering the Canadian Thalidomide Survivors Support Program pursuant to the Personal Information Protection and Electronic Documents Act, S.C. 2000, c. 5 (PIPEDA). The information will be provided to the Government of Canada in order to facilitate the administration of the Canadian Thalidomide Survivors Support Program. Personal information is protected under federal legislation, including PIPEDA and the Privacy Act, and personal information may be used or disclosed in accordance with applicable legislation. You have the right to request access to your personal information. To do so, call 1-877-507-7706 or 1-877-627-7027 (TTY).

Return to:

Canadian Thalidomide Survivors Support Program
PO Box 507 STN B, Ottawa ON K1P 5P6
info@tsspcanada.ca; Fax: 1-888-842-1332