ProPharma Group

Authorized Agent Designation Form

Instructions:

If you would like to designate an authorized agent to submit a request on your behalf related to your personal information, a signed and notarized[1] copy of this form must be submitted to us. If ProPharma Group is unable to verify the identity of the individual about whom information is being requested (the "Requestor"), we may ask for additional information or documents for verification purposes. For more information, please see our Privacy Policy.

If sending by mail, please use the following address:

Data Protection Officer
ProPharma Group
Olliver, Aske, Richmond
North Yorkshire, DL10 5HX
United Kingdom

If sending by email, please use the following address:

privacy@propharmagroup.com

1. Requestor Information

Full Name
Mailing Address
Email Address
Phone Number

2. Authorized Agent Information

Full Name of Authorized Agent
Email Address of Authorized Agent
Phone Number

3. Authorization

I, Requestor, designate the Authorized Agent listed above for the sole purpose of submitting the following request(s) on my behalf (check all that apply):

- ☐ Request to delete my personal information.
- ☐ Request to access my personal information.
- ☐ Request to modify my personal information.
- ☐ Request to object to the processing of my personal information.
- ☐ Request to restrict the processing of my personal information.

By signing below and submitting this Authorized Agent Designation form, I affirm the following:

- I am the Requestor whose name appears above, and the information provided in this form is true and accurate.
- I understand that I may be contacted directly in order to verify my identity and confirm designation of my Authorized Agent.
- I grant the Authorized Agent permission to submit the request(s) indicated above to ProPharma Group on my behalf.
- I authorize ProPharma Group to process such request(s) and I understand that any responses produced in connection with a request to access my personal information will not be sent to my Authorized Agent but will instead be sent directly to me at the address provided above.
- The authority granted by this form will terminate 90 days after the date of execution.
- I agree to indemnify ProPharma Group for any and all claims that arise against ProPharma Group in relation to its reliance on this Authorized Agent Designation form.

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[1] Notarization is only required if this request is being submitted by a U.S. resident.

Signature of Requestor	**Today's date** (*mm/dd/yyyy*)

If you are a resident of the United States, please complete the following notarization:

State of _____________ **County of** _____________

I, _________________________________, do hereby confirm that on this ______ day of ________, 20_____, the person named as the Requestor in Section 1 above appeared before me, and has acknowledged to me that this authorization is his/her wish.

Signature of notary public	**Notary seal** (*if state requires a seal*)
Commission expiration date (*mm/dd/yyyy*)	* The notary seal must be dated within 30 days of receipt of this document by ProPharma Group.