



Contact person Authorization Form

Undersigned employer,

Name:

Function:

Name Company:

hereby grants permission to the undersigned contact person

Name Contact person:

Function:

E-mailaddress:

to be allowed to process confidential information of the company and its employees, including private data and other relevant data in the event of illness, and to receive it from Mepros Bedrijfsgezondheidsdienst B.V. Both the employer and the contact person will ensure correct internal processing of this data and confirm that they have taken note of the explanation on the Contact Person Authorization Form.

This permission is granted confidential company and personal data of

Naam Company:

All Departments: ☐ Yes ☐ No, only certain departments specified below

Name Company or department:

Name Company or department:

Name Company or department:

Name Company or department:

And has the following validity:

- ☐ unlimited and valid until either employer or employee revoke the validity or the employee is no longer working at the company.
- ☐ limited until(DD-MM-YYY)

Signature employer

Signature employee