

HYPERBARIC MEDICINE FACILITY					Ref	:	WI-FR032
Related Procedure	:	Data Protection	Approved By	:	Issued	:	24/02/2019
					Reviewed	:	New
Location		Hbot/Hbot Management/Forms			Issue	:	1
Title	:	GDPR CONSENT (DONORS, BUSINESS SUPPLIERS or CONTRACTORS, COMPLAINANTS, CORRESPONDENTS, ENQUIRERS & DIRECTORS / MEMBERS of HBOT IOM.)					

In accordance with GDPR legislation this signed form is also an acknowledgement of the information we hold on record for yourself, along with the purpose and this information is for our sole use only.

The details on this form are essential for us under Financial Regulations, Companies and Charity Law and Data Protection to also be able to communicate our thanks along with any correspondence with you.

If you would like to see our privacy notice please ask or view our website. www.hbot.im

**PLEASE COMPLETE THE RELEVANT SECTION PERTAINING TO YOURSELF AND RETURN THIS FORM TO;
HBOT IOM SECRETARY OR THE DATA PROTECTION OFFICER**

CHARITABLE DONORS / CORRESPONDENCE/ ENQUIRIES (ONLY)			
Your Name (Title, First, Middle Initial ,Surname.) or Company/Charity Name & Contact			
Home/Business Address		Town	Postcode
		Telephone Number	
PREFERED METHODS OF CONTACT (ESSENTIAL FOR RECEIPTS)			
<input type="checkbox"/> POST. <input type="checkbox"/> EMAIL. <input type="checkbox"/> TELEPHONE.			
EMAIL ADDRESS:		Payment Date:	
AMOUNT DONATED: <input type="checkbox"/> Charitable Donation (Cash, Cheque or Online transaction) <input type="checkbox"/> Direct Debit <input type="checkbox"/> Standing Order <input type="checkbox"/> Paypal Payment <input type="checkbox"/> Just Giving Payment			
WOULD YOU LIKE TO RECEIVE UPDATES FROM US			
<input type="checkbox"/> I DO NOT WISH TO RECEIVE UPDATE <input type="checkbox"/> Newsletters <input type="checkbox"/> Media Releases			
PRINT NAME:		DATE:	
SIGNATURE:			

HYPERBARIC MEDICINE FACILITY				Ref	:	WI-FR032		
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DIRECTORS / MEMBERS OF HBOT IOM			
Your Name (Title, First Name, Middle Name ,Surname,)			
Home Address	Town		Postcode
		Telephone Number	
PREFERED METHODS OF CONTACT			
<input type="checkbox"/> POST. <input type="checkbox"/> EMAIL. <input type="checkbox"/> TELEPHONE.			
EMAIL ADDRESS:		Date of Appointment: Date of Resignation:	
PRINT NAME: DATE:			
SIGNATURE:			

SUPPLIERS / CONTRACTORS TO HBOT IOM			
Main Contact (Title, First Name, Middle Initial ,Surname,):			
Company Name:			
Business Address:	Town		Postcode
Website:		Telephone Number	
PREFERED METHODS OF CONTACT (ESSENTIAL FOR ACCOUNTS)			
<input type="checkbox"/> POST. <input type="checkbox"/> EMAIL. <input type="checkbox"/> TELEPHONE.			
EMAIL ADDRESS:		ACCOUNTS EMAIL(For invoices, statements, & Payments):	
PRINT NAME: DATE:			
SIGNATURE:			

Return to: Hyperbaric Medicine Facility, Scholl Building , Peel Road, Douglas, Isle of Man. IM1 5ED.