

Appendix GG – Designated Representative Form

Form Approved
OMB No. 0920-0891
Exp. Date XXXXXX



World Trade Center Health Program Designated Representative Form

Designated representatives are individuals whom you authorize to act on your behalf. Designated representatives are able to provide and obtain personal information regarding your application to the Program, your claim, and your membership in the Program. A designated representative can be anyone such as an attorney, family member, advocate, or friend. A parent or guardian may act on behalf of a minor.

You may have appointed a health care proxy or assigned a health care power of attorney to a family member or other person so that they may obtain, use, and disclose your personal information, and/or make medical treatment decisions on your behalf. Please note that a health care proxy/power of attorney is different from a designated representative. A designated representative may **not** make medical care (e.g., treatment) decisions on your behalf. If you have already appointed someone to act on your behalf regarding health care decisions and you would like for that person to also serve as your designated representative for purposes of the WTC Health Program, please complete this section.

Please note, a designated representative also differs from any attorney or licensed representative involved in any workers' compensation or other worker-related injury or illness claim you may have (as listed above).

The WTC Health Program will only recognize one designated representative at one time, and the designated representative must be properly appointed using this or other WTC Health Program forms.

By designating a representative, you are authorizing that individual to do the following:

- Serve as my representative in all matters pertaining to my membership in the World Trade Center Health Program.
- Receive and/or provide information pertaining to my membership and participation in the World Trade Center Health Program from NIOSH, including copies of factual and medical evidence contained in my records for the World Trade Center Health Program.

If you would like to authorize designated representative to act on your behalf in matters related to your WTC Health Program application and/or membership, please provide the following information:

First & Last Name _____

Relationship to the Person Applying to the WTC Health Program (e.g., spouse, parent, adult child, attorney) _____

Mailing Address _____

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta (0920-0891).

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City _____ State _____ Zip Code _____

Primary Phone: (_____) _____ - _____

I declare that the foregoing is true and correct. This authorization is effective on the date it is signed, and is effective until specifically revoked by me in writing.

Printed Name

Date

Signature

Date