

Request for Access (Article 15 GDPR), Erasure (Article 17 GDPR) and/or Further Rights of the Data Subject Pursuant to Chapter 3 of the GDPR

Name: *	
Name at birth: **	
Postal address:	
Mobile number: *	
Email: *	
Date of birth: ***	

* mandatory. We will contact you for further information on your request.

** Only if your name has changed since the time for which you request access/erasure.

*** is needed in order to avoid any possibility of confusion because of identical names.

I request:

<input type="checkbox"/>	access to my personal data processed by the University of Applied Sciences for Health Professions Upper Austria
<input type="checkbox"/>	access to my personal data processed in connection with
<input type="checkbox"/>	access to my personal data processed in connection with a particular event:
<input type="checkbox"/>	erasure of my personal data processed by the University of Applied Sciences for Health Professions Upper Austria
<input type="checkbox"/>	erasure of my personal data processed by the University of Applied Sciences for Health Professions Upper Austria in connection with a particular event or department: ...
<input type="checkbox"/>	Other rights of data subject pursuant to GDPR (General Data Protection Regulation): right to rectification/ right to restriction of processing/ right to data portability

Please give us some information so that we can be more effective in fulfilling your request.

(multiple answers possible)

<input type="checkbox"/>	I applied for a place to study.	<input type="checkbox"/>	I applied for a job.
<input type="checkbox"/>	I receive FH-News/mailings.	<input type="checkbox"/>	I teach at the University of Applied Sciences for Health Professions Upper Austria.
<input type="checkbox"/>	I am/was an incoming student. Year:	<input type="checkbox"/>	I am/was staff member.
<input type="checkbox"/>	<input type="checkbox"/> I am a student. <input type="checkbox"/> I am a graduate. Study program: ... Year: ...	<input type="checkbox"/>	I take/took part in a research-project:
<input type="checkbox"/>	I am/was in a business relationship with the University of Applied Sciences for Health Professions Upper Austria: ...	<input type="checkbox"/>	other:

Please attach a copy of your identity card, so that we can confirm your identity.

Date

Signature

Please send this request with a handwritten signature via email to datenschutz@fhgpoee.ac.at, or by mail to FH Gesundheitsberufe OÖ GmbH, Semmelweisstraße 34/D3, 4020 Linz, Austria or submit it personally at one of our locations.

Please note that we will store this request and a process protocol for three years to be able to reproduce its processing.