**Itamar Medical Ltd.**

**Form for Requests under the California Consumer Privacy Act**

Itamar Medical Ltd. and its affiliates are committed to safeguarding consumer data and complying with applicable privacy laws, including the California Consumer Privacy Act (“**CCPA**”). California residents whose personal information is covered by the CCPA have the right, subject to certain limitations, to: (i) request access to, and information about, personal information we collect and share about you; and (ii) request that we delete the personal information we have collected from you.

Upon completion of this form, please submit it to us using one of the two methods: (1) email this form to [privacy@itamar-medical.com](mailto:privacy@itamar-medical.com); or (2) call us at 1 888 748 2627. We will respond to your request or your authorized agent’s request in writing as soon as practicable and in any event generally not more than within 45 days after receipt of the request. We may extend this period to 90 days and, in the event that we do extend the period, we will explain to you or your authorized agent why we did so. The response we provide will also explain the reasons we cannot comply with a request, if applicable. For “right to know” requests, we will select a format to provide your personal information that is readily useable and should allow you to transmit the personal information from one entity to another entity without hindrance.

|  |
| --- |
| Name: Last First MI Suffix |
| Mailing Address |
| City State Zip |
| Email Telephone |

**Type of Request** (*Select Only One*):

🞎I want to know what personal information has been collected or shared.

🞎I want to delete the personal information you have about me (*exceptions may apply*).

**Relationship to Itamar Medical Ltd. or Itamar Medical Inc.** (*Select Only One*):

🞎 Website visitor

🞎 Purchaser of a product sold by Itamar Medical Ltd.

🞎 Third party vendor/consultant

🞎 Other – Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Signature  ▶ | Date (*MM/DD/YY*) |

**Attestation** *(Select Only One)*:

🞎 I declare under penalty of perjury that I am the individual consumer whose personal information is the subject of this request.

🞎 I declare under penalty of perjury that I am the authorized agent of the individual whose personal information is the subject of this request. I understand that I will be required to provide proof in writing of my status as the individual’s authorized agent and additional information to confirm my identity.

**Verification of Identity:**

**Please attach a valid photo identification document (e.g., a copy of your driver’s license, passport, or other form of identification) to this form so that we can verify your identity and residency.**