**Data Subject Request Form**[[1]](#footnote-1)

***You are not obliged to complete this form to make a request, but doing so will make it easier for us to process your request more efficiently***

**Request Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Requester Contact Information:**

First Name Last Name

*Click or tap here to enter text. Click or tap here to enter text.*

Phone Email Country

*Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text.*

Street Address City State/Province

*Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text.*

**Personal Data Request**

I would like the following:

* *Confirmation that you have my personal data*
* *Receive a copy of my personal data*
* *Update my personal data*
* *Unsubscribe from Alnylam marketing activities*
* *Withdraw consent from processing*
* *Delete my personal data*
* *Complain about use of my personal data*

**Reason for the request**

(optional)

* *You believe that your data is incomplete or inaccurate*
* *You believe processing of your personal data is no longer necessary for the original purpose*
* *You no longer consent to the processing of your personal data for a specific purpose*
* *You object to the processing of your personal data for direct marketing purposes*
* *You believe that your personal data has been unlawfully processed*

**Data Subject Details**

Same as Requester

First Name Last Name

*Click or tap here to enter text. Click or tap here to enter text.*

Phone Email Country

*Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text.*

Street Address City State/Province

*Click or tap here to enter text. Click or tap here to enter text. Click or tap here to enter text.*

**Relationship to Alnylam**

* *Job Applicant or Candidate*
* *Reference*
* *Employee/Contingent Staff*
* *Former employee*
* *Healthcare Professional*
* *Healthcare Organization*
* *Vendor*
* *Patient/Caregiver*
* *Other Private Person*

**During what time frame, from today’s date, was your Personal Data provided to Alnylam?**

* *Less than 3 months*
* *3-6 months*
* *6-12 months*
* *12 months to 2 years*
* *Two or more years*

**To what function or group at Alnylam was your Personal Data provided?**

* *Clinical*
* *Commercial (Sales and Marketing)*
* *Finance*
* *Human Resources*
* *Information Technology*
* *Legal*
* *Medical*
* *Research*

**How would you like to receive the requested data (if any)?**

* *Electronic copies*
  + *Access to secure site*
  + *Email specified above*
* *Paper copies*
  + *Post*
  + *Pick up at Alnylam Office*

**Declaration**

By submitting this form, you:

* Confirm that you have read and understood the terms of this Data Subject Request Form and that the information provided is accurate and complete.
* Confirm that you are the Data Subject named or the authorized representative of the Data Subject named in this Data Subject Request Form.
* Agree to the processing of your personal data provided in this form for the identifying of the personal data about which you are making a request, and for responding to your request.

1. Requests will receive a response within thirty (30) days of receipt by Alnylam. Additional time may be required based upon the complexity of the request, Alnylam will contact you if additional time is required to process your request.

   Verification of identity will be required.

   If the request is not submitted by the Data Subject or the parent of a minor Data Subject, this request should include confirmation that the requester has authority to act on behalf of the Data Subject (e.g., proof of guardianship, power of attorney). [↑](#footnote-ref-1)