



Authorisation form

for requesting information to assess a claim for Dutch child benefit at twice the basic rate for a child with extensive care needs

By completing and signing this form, you authorise the CIZ to contact your child's supervisor and/or treatment provider. We will only do this if we need additional information. If you do not grant us this authorisation, we may not be able to make an accurate assessment of your child's situation. This will affect the recommendation we make to the SVB.

Privacy

The CIZ will handle the information on your child with care. At www.ciz.nl/privacy, you can read how we handle your personal data. You can also read what personal data we process and what your rights are.

1. Details of the child

<i>Initials</i>	<i>First name</i>	<i>Gender</i>	
<input type="text"/>	<input type="text"/>	<input type="radio"/> Boy	<input type="radio"/> Girl
<i>Surname</i>			
<input type="text"/>			
<i>Date of birth</i>		<i>Burgerservicenummer (BSN)</i>	
<input type="text"/>	- <input type="text"/>	- <input type="text"/>	<input type="text"/>

2. Details of healthcare professional/professionals

Details of supervisors and/or treatment providers

<i>Name of supervisor or treatment provider 1</i>	<i>Job title</i>
<input type="text"/>	<input type="text"/>
<i>Name of organisation</i>	
<input type="text"/>	
<i>Place</i>	<i>Telephone number</i>
<input type="text"/>	<input type="text"/>
<i>Email address</i>	
<input type="text"/>	
<i>Name of supervisor or treatment provider 2</i>	<i>Job title</i>
<input type="text"/>	<input type="text"/>
<i>Name of organisation</i>	
<input type="text"/>	
<i>Place</i>	<i>Telephone number</i>
<input type="text"/>	<input type="text"/>
<i>Email address</i>	
<input type="text"/>	

Continue on the next page.

2. Details of healthcare professional/professionals (continued)

Details of supervisors and/or treatment providers

Name of supervisor or treatment provider 3

Job title

<input type="text"/>	<input type="text"/>
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Name of organisation

<input type="text"/>

Place

Telephone number

<input type="text"/>	<input type="text"/>
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Email address

<input type="text"/>

Details on education

Name of contact

Job title

<input type="text"/>	<input type="text"/>
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Name of organisation

<input type="text"/>

Place

Telephone number

<input type="text"/>	<input type="text"/>
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Email address

<input type="text"/>

Details of daytime activities (for instance, out-of-school care or care farm)

Name of contact

Job title

<input type="text"/>	<input type="text"/>
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Name of organisation

<input type="text"/>

Place

Telephone number

<input type="text"/>	<input type="text"/>
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Email address

<input type="text"/>

3. Signature

I hereby authorise the healthcare professional/professionals listed under 2 to provide information on my child to the CIZ.

Name of parent/guardian with parental authority

<input type="text"/>

Date

Signature

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>

Place

<input type="text"/>

► Please note that we can only process signed forms.