



**NEIGHBORHOOD HEALTH PARTNERSHIP
APPOINTMENT OF REPRESENTATIVE**

MEMBER NAME (Please print or type)

SOCIAL SECURITY NUMBER

WAGE EARNER

SOCIAL SECURITY NUMBER

I appoint the following individual, _____ (Name and Address)
to act as my representative in connection with my claim under the Title XVIII.

I authorize this individual to make or give any request or notice; to present or elicit evidence; to obtain information; and to receive any notice in connection with my pending claim or asserted right wholly in my stead.

MEMBER SIGNATURE

ADDRESS

TELEPHONE

DATE

ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspected or prohibited from practice before the Social Security Administration; that I am not, as a current or former officer or employee of the United States, disqualified from acting as the claimant's representative; and that I will not charge or receive any fee for the representative unless it has been authorized in accordance with the laws and regulations.

I am a/an _____. (Attorney, union representative, relative, law student, etc.)

SIGNATURE OF REPRESENTATIVE

ADDRESS

TELEPHONE

DATE