



International Organization for Migration (IOM)
Kansainvälinen siirtolaisuusjärjestö (IOM)
Internationella migrationsorganisationen (IOM)

VOLUNTARY RETURN DECLARATION AND AUTHORIZATION FOR COLLECTION OF PERSONAL DATA

I, the undersigned, _____, express my informed decision to return voluntarily to my home country or a third country (where I'm entitled to permanent residence), which is _____, through the assistance of the International Organization for Migration (hereinafter, "IOM"). I understand that I will not be allowed to stop over in any transit country.

I understand that the personal data of myself and my dependents [list all children/family members]:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

are necessary for the provision of IOM's assistance in the framework of an Assisted Voluntary Return and Reintegration project. The project aims to provide assistance to voluntary return and reintegration. I have been informed about the specified and additional purpose(s) and hereby authorize IOM and any authorized person or entity acting on behalf of IOM to collect, use, disclose and dispose of the personal data provided in this form. I am aware and agree that the personal data will be shared with and processed by the Finnish Immigration Service, Reception Centres in Finland, Police of Finland, and Border Guards, to achieve the specified purpose(s).

I hereby, for myself, as well as for my dependents, heirs and estate, release, discharge and agree to hold harmless IOM from any liability or damage caused, directly or indirectly, to me, my child or my family in connection with this authorization. I agree, for myself, as well as for my dependents, heirs and estate, that in the event of personal injury or death during and/or after my participation in the IOM project, neither IOM, nor any other participating agency or government can in any way be held liable or responsible.

I declare that the information I have provided is true and correct to the best of my knowledge. I understand that if I make a false statement in signing this form, the assistance provided by IOM can be terminated at any time.

Signed on _____ at _____
date place Applicant's signature

Signature of the Representative of IOM
or delegate partner (social worker)

Interpreter's signature [if applicable]

[IOM STAMP]