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|  | Директору ООО «МЦ «Медика» |
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|  | от |
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|  |  |
|  | (ФИО) |
|  | фактический адрес: |
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|  |  |
|  |  |
|  | тел.: |
|  | email: |
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**Заявление**

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(ФИО)

являюсь пациентом ООО «МЦ «Медика» (поликлиника АВЕНЮ),

дата посещения: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

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Прошу *(укажите пожалуйста, каких действий Вы ждете от медицинской организации):*

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Дата: "\_\_\_\_\_" \_\_\_\_\_\_\_\_\_\_\_\_\_ 20\_\_\_\_\_\_ г.

Заявление принято работником ООО «МЦ «Медика»: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

подпись расшифровка

Копию получил.

Подпись пациента/законного представителя пациента: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

подпись расшифровка