

8. számú melléklet

a Térítési Díj Szabályzathoz, Érvényes TAJ kártyával nem rendelkező, magyarul nem beszélő beteg nyilatkozata (angol)

DISCLAIMER

Surname:

First name:

Address:

(country, settlement, poste code, number, street)

e-mail address:

Date of birth:

Place of birth:

Nationality:

Passport number:

I, the undersigned certify that all the data appearing here are valid.

I received healthcare at Semmelweis University from(dd/mm/yyyy)
to(dd/mm/yyyy / on (dd/mm/yyyy).

I declare that I am entitled to medical treatment as an insured citizen of the European Economic Area. I understand that failing to present the document verifying my eligibility, the National Health Insurance Fund Administration requests the competent body based on my citizenship to verify that.

I declare that I am entitled to medical treatment based on my other insurance. I understand that the validity of such insurance has to be verified.

I declare that I do not possess insurance that makes me eligible to receive medical treatment; therefore I am obliged to pay the treatment fee until the **deadline indicated on the receipt**.

I understand that by not being eligible to receive medical treatment, I am obliged to pay the treatment fee **until the deadline indicated on the receipt**.

I understand that failing to pay the fee of the treatment **until the deadline indicated on the receipt** Semmelweis University is entitled to act according to official wind-up procedure.

Fee of health care received is to be transferred to account: 10032000-00282819-00000000 (MÁK)

Date:

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signature