

Érvényes TAJ kártyával rendelkező, de azt ellátásakor bemutatni nem tudó, magyarul nem beszélő beteg nyilatkozata (angol)

DISCLAIMER

Surname:

First name:

Address:

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

E-mail address:

Date of birth:

Place of birth:

Nationality:

Passport/ID number:

I received medical treatment at Semmelweis University from
(dd/mm/yyyy) to(dd/mm/yyyy) / on
(dd/mm/yyyy)

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

I understand that my **social security number, valid during the period of the treatment** has to be presented at Semmelweis University **within 15 days for verification**. Failing to prove the validity of my social security number I am obliged to pay the **treatment fee within 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.

The fee of the medical treatment is to be transferred to the following account number: 10032000-00282819-00000000 (MÁK)

Date:

.....
signature