Érvényes TAJ vagy EU 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: 11784009-22236665-00000000 (OTP Bank)

Date: ………………………………………..

……………………………………
signature

made: 2 copies
1. copies.: Szervezeti egység
2. copies: patient