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| 様式第28号 | | | | | | | | | | | | | | | | |  |
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| 自立支援医療受給者証再交付申請書（育成医療・更生医療） | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | |  |
| 土佐清水市福祉事務所長　様 | | | | | | | | | |  | | | | | | |  |
|  | | | | | | | | | | | | | | | | |  |
| 次のとおり医療受給者証の再交付を申請します。 | | | | | | | | | | | | | | | | |  |
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|  | | | | | | | | | 申請年月日 | | | | | 年 月 日 | | |  |
| 受　診　者 | フリガナ |  | | | | | | | | | | | | 生年月日 | | |  |
| 氏　名 |  | | | | | | | | | | | | 年 月 日 | | |  |
| フリガナ |  | | | | | | | | | | | | | | |  |
| 住　所 |  | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | 電話番号 | |  | |  |
| 保護者（受診者が１８ 歳未満の場合記入） | | フリガナ | | |  | | | | | | | | | | 続柄 | |  |
| 氏　名 | | |  | | | | | | | | | |  | |  |
| フリガナ | | |  | | | | | | | | | | | |  |
| 住　所 | | |  | | | | | | | | | | | |  |
|  | | | | | | | | 電話番号 | |  | |  |
| 自立支援医療費受給者番号 | |  |  |  | |  |  |  | |  | |  |  | | | |  |
| 医療受給者証の有効期限 | | 年 月 日 | | | | | | から | | | 年 月 日 | | | | | まで |  |
| 申　請　の　理　由 | |  | | | | | | | | | | | | | | |  |
| 注　１　医療受給者証を破り、又は汚した場合の申請については、現在お持ちの医療受給 | | | | | | | | | | | | | | | | |  |
| 者証を添付してください。 | | | | | | | | | | | | | | | | |  |
| ２　再交付を受けた後、失った医療受給者証を発見したときは、速やかに市に返還し | | | | | | | | | | | | | | | | |  |
| てください。 | | | | | | | | | | | | | | | | |  |
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