IESNIEGUMS

**EIROPAS VESELĪBAS APDROŠINĀŠANAS KARTES
AIZVIETOJOŠĀ SERTIFIKĀTA (EVAK AS) SAŅEMŠANAI**

Aizpildīšanas datums: \_\_ \_\_.\_\_ \_\_.\_\_ \_\_ \_\_ \_\_.

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| **Informācija par EVAK AS saņēmēju** |
| Vārds, uzvārds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dzimšanas datums: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Pilsonības valsts: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Deklarētās dzīvesvietas valsts: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Personas kods vai NMR kods: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Citā valstī piešķirtais ID numurs: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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| **Informācija par EVAK AS pieteicēju (aizpilda, ja EVAK AS pieprasa cita persona)**  |
| Vārds, uzvārds: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Personas kods vai NMR kods: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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| Pārstāvības pamats:  |
| * Nepilngadīgas personas vecāks/aizbildnis vai pilngadīgas personas aizgādnis
 |
| * Pilnvarotā persona
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| **Kontaktinformācija (informācijas precizēšanai)**  |
| Tālruņa numurs: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| E-pasta adrese: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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| **EVAK AS informācija** |
| Veselības aprūpes pakalpojums saņemts no \_ \_.\_ \_.\_ \_ \_ \_ līdz \_ \_.\_ \_.\_ \_ \_ \_.  |
| Ārstniecības iestādes nosaukums: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| Ārstniecības iestādes adrese un/vai e-pasta adrese, uz kuru jānosūta EVAK AS: |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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| **Apliecinu,** ka  |
| * visa augstāk sniegtā informācija ir pilnīga, pareiza un patiesa;
 |
| * piekrītu savu personas datu izmantošanai EVAK AS saņemšanai;
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| * EVAK AS saņēmējs nav nodarbināts vai pašnodarbināts citā ES, EEZ dalībvalstī vai Šveicē, nesaņem pensiju vai pabalstus no citas dalībvalsts un nav tiesīgs saņemt valsts apmaksātus veselības aprūpes pakalpojumus citā dalībvalstī.
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| **Iesnieguma iesniedzēja paraksts:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |