Главному врачу федерального государственного бюджетного учреждения «Федеральный центр травматологии, ортопедии и эндопротезирования» Министерства здравоохранения Российской Федерации (г. Смоленск)

А.В. Овсянкину

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(Ф.И.О. полностью)

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(адрес проживания)

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(телефон)

заявление.

Прошу Вас предоставить в налоговый орган в электронной форме Справку об оплате медицинских услуг для предоставления в налоговый орган (форма по КНД 1151156) за оказанные медицинские услуги в ФГБУ «ФЦТОЭ» Минздрава России (г. Смоленск).

Данные физического лица (его супруга/супруги), оплатившего медицинские услуги (далее - налогоплательщик):

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Фамилия |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Имя |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Отчество |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| ИНН <2> |  |  |  |  |  |  |  |  |  |  |  |  |  | Дата рождения |  |  | **.** |  |  | **.** |  |  |  |  |  |  |  |  |  |  |

Сведения о документе, удостоверяющем личность:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Код вида документа |  |  | Серия и номер |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Дата выдачи |  |  | **.** |  |  | **.** |  |  |  |  |  |  |  |  |  |  |

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| Налогоплательщик и пациент являются одним лицом | | | | | | |  | 0 – нет  1 - да |  |  |  |  |  |  |
| Отчетный год |  |  |  |  |  |

Данные физического лица, которому оказаны медицинские услуги [<1>](#Par130):

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Фамилия |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Имя |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Отчество |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| ИНН <2> |  |  |  |  |  |  |  |  |  |  |  |  |  | Дата рождения |  |  | **.** |  |  | **.** |  |  |  |  |  |  |  |  |  |  |

Сведения о документе, удостоверяющем личность:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Код вида документа |  |  | Серия и номер |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Дата выдачи |  |  | . |  |  | . |  |  |  |  |  |  |  |  |  |  |

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<1> Данные заполняются, если налогоплательщик и пациент не являются

одним лицом.

<2> ИНН указывается при наличии.

Достоверность и полноту сведений, указанных в данном заявление, подтверждаю:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (подпись) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (дата)