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| Генеральному директору | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| ЗАО «Центр Флебологии» | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| 117869, г. Москва, Новоясеневский проспект, д. 6, корп. 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **от налогоплательщика** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| Контактный телефон: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| e-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| **ЗАЯВЛЕНИЕ** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| Прошу выдать справку об оплате медицинских услуг, оказанных \_\_\_\_\_\_\_\_\_  (указать кому оказаны услуги: мне, супругу, супруге, сыну, дочери, матери, отцу)  для представления в налоговые органы для получения социального налогового вычета за \_\_\_\_\_\_\_\_ год. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **ФИО и дата рождения пациента, получившего услуги:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| **(дата рождения \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| Подпись\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | \_\_\_\_\_\_ 2023 г. | | | | | | | | | |  |
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| Заявление принял: администратор\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  |