Генеральному директору ООО «СЦЗ»

Гавриловой Н. А.

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ЗАЯВЛЕНИЕ

Прошу выдать справку об оплате медицинских услуг для предоставления в налоговую службу Российской Федерации (ФНС) для оформления налогового вычета на расходы по лечению.

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| Отчетный год: |  |  |  |  |

Данные налогоплательщика, оплатившего медицинские услуги:

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| Фамилия | | | | | | | |  | |  |  |  |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
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| Имя | | | | | | | |  | |  |  |  |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
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| Отчество | | | | | | | |  | |  |  |  |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
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| ИНН  <2> | | | | | |  | |  | |  |  |  |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | | Дата рождения | | | | | | | | | | | | | | | | | |  | |  | | . | |  | |  | | . | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
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| Сведения о документе, удостоверяющем личность: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |
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| Код вида документа | | | | | | | | | | |  |  | |  | |  | |  | |  | |  | |  | | Серия и номер | | | | | | | | | | | | | | | | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | | |
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| Дата выдачи | | | | | | |  | |  | | . |  | |  | | . | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |

Налогоплательщик и пациент являются одним лицом <1>:

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| <1> Если налогоплательщик и пациент являются одним лицом, то заполнять данные пациента не требуется.  <2> ИНН указывается при наличии. |

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| Данные пациента лица, которому оказаны медицинские услуги: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
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| Фамилия | | | | | | | |  | |  |  |  |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
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| Имя | | | | | | | |  | |  |  |  |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
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| Отчество | | | | | | | |  | |  |  |  |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
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| ИНН  <2> | | | | | |  | |  | |  |  |  |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | | Дата рождения | | | | | | | | | | | | | | | | | |  | |  | | . | |  | |  | | . | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |
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| Сведения о документе, удостоверяющем личность: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |
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| Код вида документа | | | | | | | | | | |  |  | |  | |  | |  | |  | |  | |  | | Серия и номер | | | | | | | | | | | | | | | | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | | |
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| Дата выдачи | | | | | | |  | |  | | . |  | |  | | . | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |  | |  | |  | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |

Кем налогоплательщик приходится пациенту? <3> \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

<3> *Муж, Жена, Отец, Мать, Сын, Дочь, Опекун*

**\*Справка об оплате медицинских услуг выдается лично на руки налогоплательщику, производившему оплату, либо представителю налогоплательщика на основании доверенности.**

**\*\*Заявление заполняется печатными буквами.**

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| **Достоверность и полноту сведений, подтверждаю:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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Дата заявления \_\_\_\_\_\_\_\_\_\_\_ Подпись\_\_\_\_\_\_\_\_\_\_\_ / Расшифровка\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/

**Справку получил(а):**

Дата получения\_\_\_\_\_\_\_\_\_\_\_ Подпись\_\_\_\_\_\_\_\_\_\_\_ / Расшифровка\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/