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| logo KBSM[1] | **KLINIČKI BOLNIČKI CENTAR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **SESTRE MILOSRDNICE**  Vinogradska cesta 29 tel.: 01/3787 111  HR-10000 Zagreb fax.: 01/37 69 067 Hrvatska |

**ZAHTJEV ZA IZDAVANJE PRESLIKE**

**MEDICINSKE DOKUMENTACIJE**

Podaci podnositelja zahtjeva

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(ime i prezime)

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(adresa)

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(datum rođenja)

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(OIB)

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(kontakt i email adresa)

Molim da mi izdate presliku \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(naziv dokumenta)

s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ iz \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(klinika/klinički zavod/zavod) (datum/godina)

U Zagrebu, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(datum) (potpis podnositelja zahtjeva)

Uz zahtjev je potrebno priložiti presliku osobne iskaznice.