様式第6号(第8条関係)

年　　　月　　　日

　　　　福井県知事　　様

申請者　住所

氏名

自立支援医療受給者証再交付申請書

　　　下記の理由により、自立支援医療受給者証の再交付を受けたいので申請します。

記

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 受給者番号 | | | | |  | |  | | | | |  | | | | |  | | | |  | | | | |  | | | | |  | | |
| 医療の種類 | | | | | 精神通院医療 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受　診　者 | | | 住　　所 | | 郵便番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏　　名 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 生年月日 | | 年　　　　月　　　　日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 電話番号 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 | |  |  | |  | |  | | |  | |  | | |  | | | |  | |  | | |  | |  | | |  | |
| (受診者が | | 保　　護　　者 | 住　　所  ※1 | | 郵便番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏　　名 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18 | |
| 歳未満の場合) | |
| 電話番号  ※2 | |  | | | | | | | | | | | | | | | 続柄 | | | | |  | | | | | | | | |
| 個人番号 | |  |  | | |  | |  | | |  | |  | | |  | | | |  | |  | | |  | |  | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 再交付の理由 | | | 1　破　損  　2　汚　損  　3　紛　失  　4　その他（　　　　　　　　　　　　　　　　　　　　　　　　) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

　　　備考

　　　　※1および※2は、受診者本人と異なる場合に記入してください。