様式第２８号

自立支援医療（育成医療・更生医療）受給者証再交付申請書

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 受診者 | フリガナ |  | | | | | | | | | | | | | | | | 性別 | | | | | 生年月日 | | | | | | | | | |
| 氏名 |  | | | | | | | | | | | | | | | | 男・女 | | | | | 年　　月　　日 | | | | | | | | | |
| フリガナ |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所 | 電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 |  | |  | |  | | |  | | |  | | |  | | | |  | | |  | | |  | |  | |  | |  | |
| 保護者（受診者が18歳未満の場合記入） | | フリガナ | | | |  | | | | | | | | | | | | | | | | | | | | | 続柄 | | | | | |
| 氏名 | | | |  | | | | | | | | | | | | | | | | | | | | |  | | | | | |
| フリガナ | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 住所 | | | | 電話番号 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 個人番号 | | | |  | |  | | |  | | |  | | |  | | | |  |  | |  | |  | |  | |  | |  |
| 自立支援医療費受給者番号 | |  |  | |  | |  | | |  | | |  | | |  | | | |  | |  | | | | | | | | | | |
| 受給者証の有効期間 | | 年　　月　　日から　　　　年　　月　　日まで | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 再交付申請理由 | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 自立支援医療受給者証の再交付について、上記のとおり申請します。  申請者氏名  　年　　月　　日  　　　中新川郡舟橋村長　宛 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

（注）　１　自立支援医療受給者証を破り、又は汚した場合の申請については、現在お持ちの自立支援医療受給者証を添付してください。

　　　　２　再交付を受けた後、失った自立支援医療受給者証を発見したときは、速やかに町に返還してください。