



15052018-VI

**ጤና ህክምና ለማረጋገጥ የሚያስፈልግ ምርመራ ሪፖርት ለማድረግ የሚያስፈልጉትን መረጃዎች ይሙሉ።**



ይህ ሪፖርት ለምርመራው የሚያስፈልገውን መረጃ በቀጣይ ለማረጋገጥ የሚያስፈልግ ሲሆን፣ ለምርመራው የሚያስፈልገውን ማረጋገጫ ማድረግ ይኖርዎታል።

**1- የሰው ልጅ መረጃ**

1-1 የሰው ልጅ ስም ማረጋገጫ፡	<input type="text"/>
1-2 የሰው ልጅ ዕድሜ ማረጋገጫ፡	<input type="text"/>
1-3 የዕድሜ ሰነድ ማረጋገጫ፡	<input type="text"/>

**2- የሕክምና ሪፖርት ማረጋገጫ**

2-1 የሕክምና ሪፖርት ማረጋገጫ፡	<input type="text"/>
2-3 የሕክምና ሪፖርት ወቅት ማረጋገጫ፡	<input type="text"/>
2-4 የሕክምና ሪፖርት ማረጋገጫ፡	<input type="text"/>

**3- የሕይወት ሁኔታ**

የሕይወት ሁኔታ ማረጋገጫ ለማድረግ የሚያስፈልገውን መረጃ ይሙሉ።

3-1 ስም ማረጋገጫ፡

3-2 የሰው ልጅ ዕድሜ ማረጋገጫ፡

3-3 የሰው ልጅ ስም ማረጋገጫ፡

3-4 የሕይወት ሁኔታ ማረጋገጫ፡

**4 - የትምህርት ማረጋገጫ**

4-1 የትምህርት ማረጋገጫ ለማድረግ የሚያስፈልገውን መረጃ ይሙሉ። (ሰዎች / የሰው ልጅ ዕድሜ ማረጋገጫ) ለምርመራው የሚያስፈልገውን መረጃ ይሙሉ።

4-2 የትምህርት ማረጋገጫ ማረጋገጫ፡

4-3 የትምህርት ማረጋገጫ ማረጋገጫ፡

4-4 የትምህርት ማረጋገጫ ማረጋገጫ፡

4-5 የትምህርት ማረጋገጫ ማረጋገጫ፡

**4 የትምህርት ማረጋገጫ ማረጋገጫ**

የትምህርት ማረጋገጫ ማረጋገጫ ለማድረግ የሚያስፈልገውን መረጃ ይሙሉ።

የትምህርት ማረጋገጫ ማረጋገጫ	የትምህርት ማረጋገጫ ማረጋገጫ	የትምህርት ማረጋገጫ ማረጋገጫ
ስም ማረጋገጫ	ስም ማረጋገጫ	ስም ማረጋገጫ
ዕድሜ ማረጋገጫ	ዕድሜ ማረጋገጫ	ዕድሜ ማረጋገጫ
የትምህርት ማረጋገጫ ማረጋገጫ	የትምህርት ማረጋገጫ ማረጋገጫ	የትምህርት ማረጋገጫ ማረጋገጫ

የትምህርት ማረጋገጫ ማረጋገጫ	የትምህርት ማረጋገጫ ማረጋገጫ
ስም ማረጋገጫ	የሰው ልጅ ስም ማረጋገጫ
ዕድሜ ማረጋገጫ	የሰው ልጅ ዕድሜ ማረጋገጫ



**Request for Medical Assistive Device or Financial Aid for Medical Assistive Devices**

15052018-VI



This Form should only be filled if the financial aid required is for a machine that is necessary for the patient to remedy a life threatening situation or to safeguard against a permanent disability.

**1- PATIENT DETAILS:**

1.1- Patient Name: <input style="width: 300px;" type="text"/>	1.2- ID Number: <table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td></tr></table>							
1.3- Contact Number: <input style="width: 250px;" type="text"/>								

**2- DETAILS OF THE MACHINE / DEVICE:**

2.1- Name of the Machine / Device:	<input style="width: 90%; height: 25px;" type="text"/>
2.2- Name of Machine / Device Provider:	<input style="width: 90%; height: 25px;" type="text"/>
2.3- Quotation No:	<input style="width: 90%; height: 25px;" type="text"/>

**3- DECLARATION:**

I hereby agree to use any aid provided solely for the purpose mentioned on this application. If the aid granted is financial, I agree to submit the receipt within 30 days of the purchase of the machine to NSPA and to return any remaining balance to NSPA. If I am found in violation of the above, NSPA has the right to reject any future applications.

3.1- Name: <input style="width: 380px;" type="text"/>	3.2- ID Number: <table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td><td style="width: 25px;"> </td></tr></table>								
3.3- Signature of Patient: <input style="width: 280px; height: 30px;" type="text"/>	3.4- Date: <table border="1" style="width: 100%; height: 20px;"><tr><td style="width: 20px;">D</td><td style="width: 20px;">D</td><td style="width: 20px;">M</td><td style="width: 20px;">M</td><td style="width: 20px;">Y</td><td style="width: 20px;">Y</td><td style="width: 20px;">Y</td><td style="width: 20px;">Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		

**4- DOCTOR'S RECOMMENDATION:**

4.1- The machine/device requested in this application is required by (patient name: ...../ NID No:.....) for the purpose of his/her advised treatment.

4.2- Further Justification (if necessary):

4.3- Doctor's Name:

4.4- Date: 

D	D	M	M	Y	Y	Y	Y
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 4.4- Stamp and Signature:

**5- ADDITIONAL DOCUMENTS REQUIRED:**

The quotation for the requested machine / device with brand and model number specified.

Application Received By:	Application Entered By:	Application Verified By:
Name: _____ Date: _____	Name: _____ Date: _____	Name: _____ Date: _____
Office: _____ Time: _____	Designation: _____ Date: _____	Designation: _____ Date: _____
Sign: _____ Stamp: _____	Time: _____ Sign: _____	Time: _____ Sign: _____



Application Received By:	Application Submitted By:	Form Number:
Name: _____ Date: _____ Stamp: _____	Full Name: _____	ID Card Number: _____
Office: _____ Time: _____ Sign: _____	Permanent Address: _____	