



BUDAI EGÉSZSÉGGKÖZPONT

CERTIFICATION

For obtaining health care for immediate family members (parent, sibling, spouse, child) at a discounted rate

I, the undersigned, (DOB:

Mother's Name:), as an employee/partner of Kft./Zrt. do, hereby, certify that the **person(s) listed below are members of my immediate family** and that the data included herein below is true and correct.

I do, hereby, also authorize the **Budai Egészségközpont Korlátolt Felelősségű Társaságot (Buda Health Center Ltd.)** (Registration No.: 01-09-692609, Tax ID: 12560044-2-43, 1126 Budapest, Nagy Jenő u. 8.), to forward any and all medical documents, deemed as such according to Statute §1997. XLVII, as well as other health care material, to any of the addresses listed below.

This certification shall be valid until the time of its revocation.

1. Name:

Mother's Name:

Address:

Place and Date of Birth:

TAJ No.: - -

Telephone No.: +36 - -

2. Name:

Mother's Name:

Address:

Place and Date of Birth:

TAJ No.: - -

Telephone No.: +36 - -

3. Name:

Mother's Name:

Address:

Place and Date of Birth:

TAJ No.: - -

Telephone No.: +36 - -

4. Name:

Mother's Name:

Address:

Place and Date of Birth:

TAJ No.: - -

Telephone No.: +36 - -

Budapest,

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Signature

BUDAI EGÉSZSÉGGKÖZPONT KFT.

1126 BUDAPEST, NAGY JENŐ U. 8. T: +36 1 489 5200 F: +36 1 489 5210 E: INFO@BHC.HU W: WWW.BHC.HU

ORSZÁGOS GERINCGYÓGYÁSZATI KÖZPONT

A Budai Egészségközpont Szakkórháza

1126 BUDAPEST, KIRÁLYHÁGÓ U. 1-3. T: +36 1 887 7960 F: +36 1 887 7969 E: INFO@OGK.HU W: WWW.OGK.HU