**DECLARACION JURADA DE POBLACION ASISTIDA**

Mendoza, ***SELECCIONE FECHA***

**A LA SR/A**

**MINISTRO DE SALUD,**

**DESARROLLO SOCIAL Y DEPORTES**

El que suscribe  *NOMBRE Y APELLIDO*  DNI  *DNI*  en mi carácter de  *TITULAR / APODERADO*  de la institución  *NOMBRE DE LA INSTITUCION* , declaro bajo juramento que actualmente la totalidad de pacientes que se encuentran internados o asisten a la institución que represento, asciende a la cantidad de  *CANTIDAD*

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| --- | --- | --- | --- | --- |
| **PACIENTE** | **EDAD** | **INSTITUCION DERIVANTE (obra social, otros)** | **CENTRO DE DIA** | **HOGAR** |
| *PACIENTE* | *EDAD* | *NOMBRE INSTITUCION* | *CENTRO DE DIA* | *HOGAR* |
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DIRECTOR TECNICO

Firma y aclaración

TITULAR O APODERADO DE LA EMPRESA

Firma y aclaración