**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