**省教科文卫体工会工委在榕直属学校（单位）和**

**省总工会在榕直属企业工会在职职工**

**第三期医疗互助活动补助金申请表**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **参加互助活动时间：自** | | | | | | | **年** | **月** |  | **日起到** | | |  | **年** | **月 日止** | | |  |  |  |
|  |  | **编号：** | | | **工会名称（盖章）：** | | | | | | | | | |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  | 姓名： | |  |  |  | 性别： | | |  | 身份证号： | | | | | |  |  |  |  |  |  |
| 申 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 疾病 | |  |  |  | 确诊 | |  |  | 医院 | | | |  | 确诊时间： | | | 年 月 日 | |  |  |
| 请 |  |  |  |  |  |  |  |  |  |
|  | 名称： | |  |  |  | 医院： | | |  | 等级： | | | |  |  |  |
| 人 |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 住院时间： | | | 年 月 | | 日 时至 | | | 年 月 日 时 | | | | | | 住院天数 | |  |  |  |  |  |
| 情 |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 住址： | |  |  |  |  |  |  |  |  |  |  |  |  | 联系电话： | | |  |  |  |  |
| 况 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | 申请人银行帐号： | | | | |  |  |  |  |  |  |  |  | 开户行名称： | | | |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  | | |  |
| 委 | |  |  | 我自愿委托 | | |  |  |  |  | 同志为我申请职工医疗互助活动补助（慰问）金。 | | | | | | | | | | | |
| 托 | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 书 | |  |  |  |  |  |  |  |  |  | 委托人签章： | | | | | |  |  | 年 | 月 | 日 | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 所在 | | |  |  |  |  |  |  |  |  |  |  | 所在 | | 姓 名： | |  |  |  |  |  |  |
| 工会主席（签章）： | | | |  |  |  |  |  |  | 工会 | |  |  |  |  |  |  |
| 工会 | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | 工作 | |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  | 联系电话： | | | |  |  |  |  |
| 意见 | | |  |  |  |  |  |  |  |  |  |  | 人员 | |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 职 工 | | | 初核（经办）： | | | |  |  | 审核（医学）： | | | | | |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 服 务 | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 中 心 | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 意 见 | | | 签名： | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 签名： |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | | |  | |  | | |  |  | | |  |  |  |  | | | |  | |  |  |
| 小手术补助金 | | | | | 住院补助金 | | |  | 特定疾病补助金 | | | | | 重大疾病补助金 | | | | | 死亡慰问金 | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |
|  |  |  |  | 元 |  |  | 元 |  |  |  |  |  | 元 |  |  |  | 元 | |  |  | 元 | |
|  | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 补助金额 | | | |  | 万 | |  |  | 仟 | 佰 |  |  | 拾 | | 元 | | 角 | | 分 ￥ |  |  |  |
| （大写） | | | |  |  |  |  |  |  |  |  |
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| 复核（财务）： | | | | |  |  |  |  |  |  |  |  | 中心主任意见： | | | |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |