**MODULO RIMBORSO CERTIFICATO MEDICO/**

**ANTRAG AUF ERSTATTUNG DES ÄRZTLICHEN ZEUGNISSES MIT BEIGEFÜGTER QUITTUNG**

**(Allegato n. 3/ Anhang 3)**

Al **Comitato Italiano Paralimpico**

Via Flaminia Nuova, 830 - 00191 ROMA

CF/P.IVA 14649011005

**Oggetto: richiesta di rimborso spese certificato medico/ Antrag auf Kostenerstattung Ärztliches Attest**

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| Il sottoscritto/der Unterzeichneter | | | |  | | | |
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| Residente a/ Wohnort | | |  | |  | Prov. |  |
| In via/ Adresse |  | | | | | | |

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| Assistito della sede INAIL/Betreut der INAL |  |

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| chiede di ricevere la somma di €/ beantragt die Erstattung von €: | |  | | |
| (in lettere/ in Buchstaben: |  | | /00) |
| a titolo di rimborso per le spese sostenute per il certificato medico sportivo per partecipare al “Campus Estivo CIP - INAL EMILIA ROMAGNA, TRENTO E BOLZANO”/ für die Erstattung der Kosten für das ärztliche Sportliche Zeugnis für die Teilnahme am “Sommer Camp CIP – INAIL EMILIA ROMAGNA, TRIENT UND BOZEN” | | | | | |

da accreditare presso il seguente c/c/ auf das folgende Konto:

IBAN:

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**Si allega ricevuta di pagamento del certificato/ Die Quittung der Zahlung des Arztlichen Zeugnisses wird beigelegt.**

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(*Luogo, Data)/(Ort, Datum)*

FIRMA/UNTERSCHRIFT

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