**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**

|  |  |
| --- | --- |
| Il sottoscritto/der Unterzeichneter |   |
| Nato/a a/Geburstsort  |  | Il/am |  |
| Residente a/ Wohnort |  |  | Prov. |  |
| In via/ Adresse |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| C | F |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| Assistito della sede INAIL/Betreut der INAL  |  |

|  |  |
| --- | --- |
| 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:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| I | T |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | , |  |  |

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

 FIRMA/UNTERSCHRIFT

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_