|  |  |
| --- | --- |
|  | **СПЕЦИФИКАЦИЯК ДОГОВОРУ № от на оказание платных медицинских услуг** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | "Пациент" |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Кодуслуги** | **Наименованиеуслуги** | **Коли-чествоуслуг** | **Стоимостьуслуги** | **Сумма(руб.)** | **Заведующийотделением** | **Старшаямедсестра** | **Отделение** |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |
| --- | --- |
|  | Всего оказано услуг на сумму:  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **Подписи сторон** |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **От имени Исполнителяпредставитель по доверенности** |  | **Пациент (Законный представитель)** |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  | ✔ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | подпись |  | расшифровка подписи |  | подпись |  | расшифровка подписи |  |  |  |  |  |  |  |  |  |  |  |  |