

Ministry of Public Health

Confirmation Letter for 90-day Stay on Medical Ground

Patient's Name:	Passport No.
Nationality:	Sex: Male Female
procedures under my attendand The conditions to be treated an	e patient has been accepted for treatment and/or medical ce during the period described below.
Name of Hospital: Address: Telephone:	Fax:
 Passport NO Nationality 2. First Name/Last Name Passport NO Nationality 3. First Name/Last Name Passport NO 	
Payment for this medical servi	ce is to be paid by:
(Name of the Payer Agency☐ Health Insurance/Life Insurance/Life	
U Other Health Plan	
	(Signature)(Authorized Representative)
	Date () Nameand Capacity)