ΚΥΠΡΙΑΚΗ ΔΗΜΟΚΡΑΤΙΑ

ΥΠΟΥΡΓΕΙΟ ΥΓΕΙΑΣ

APPLICATION OF PATIENTS' RIGHTS IN CROSS-BORDER HEALTHCARE LAW (L.149(I)/2013)

APPLICATION FORM FOR THE PROVISION OF INFORMATION (ARTICLE 8(4))

SECTION I: PERSONAL DETAILS OF THE APPLICANT

Name:..... Surname.....

Date of Birth...../...../..... Identification Card No:.....

Address:....., No.: ....., City/Town:.....

Postal Code:....., District:....., Country: .....

Telephone No.: ....., E-mail :.....

Facsimile No:.....

SECTION II: KIND OF REQUIRED INFORMATION

(A short description of the required information)

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.....

.....

SECTION III: PURPOSE FOR WHICH THE INFORMATION IS REQUIRED

.....

.....

SECTION IV: WAY OF RECEIVING INFORMATION

(Please select one of the followings)

☐ REGULAR MAIL ☐ E-MAIL ☐ FACSIMILE

Signature: ..... Date: .....

Note.: *The present application form should be returned* ***duly completed*** *to the National Contact Point for Cross-Border Healthcare through e-mail: ncpcrossborderhealthcare@moh.gov.cy or through electronic submission in the website of the National Contact Point for Cross-Border Healthcare or through facsimile on +357 22 605 499 / 492 or through regular mail or by Hand to the Ministry of Health, 1 Prodromou and 17 Chilonos street, 1448 Nicosia, Cyprus.*