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

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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.*