



Ministry of Public Health

Confirmation Letter for 90-day Stay on Medical Ground

Patient's Name: _____ **Passport No.** _____

Nationality: _____ **Sex:** Male Female

This is to certify that the above patient has been accepted for treatment and/or medical procedures under my attendance during the period described below.

The conditions to be treated and the procedures are:

Medical conditions: _____

Planned procedures: _____

Treatment period: _____

Name of Hospital: _____

Address: _____

Telephone: _____ Fax: _____

Name of Attending Physician: _____

Medical license Number: _____

List of entourages:

1. First Name/Last Name.....
 Passport NO.Sex: Male Female
 Nationality.....Relationship.....
2. First Name/Last Name.....
 Passport NO.Sex: Male Female
 Nationality.....Relationship.....
3. First Name/Last Name.....
 Passport NO.....Sex: Male Female
 Nationality.....Relationship.....

Payment for this medical service is to be paid by:

- The patient
- The Government of.....
 (Name of the Payer Agency.....)
- Health Insurance/Life Insurance
- Other Health Plan.....

(Signature).....(Authorized Representative)

Date (...../...../.....)

Name.....and Capacity.....