BUDAI EGÉSZSÉGKÖZPONT

*Biztonság és szakértelem*

# CERTIFICATION

For obtaining health care for immediate family members (parent, sibling, spouse, child) at a discounted rate

I, the undersigned,………………………………………………………………………………………………………… (DOB: ……………………………………………

Mother's Name: ……………………………………………………), as an employee/partner of …………………………………………………….. Kft./Zrt. do, hereby, certify that the **person(s) listed below are members of my immediate family** and that the **personal data included herein below is true and correct.**

I do hereby declare that I am entitled to share the personal data provided herein with the **Buda Health Center** (Budai Egészségközpont Zrt., *1126 Budapest, Királyhágó u. 1-3., Reg.Nr.:01-10-141707)*. I informed the persons concerned of the processing of their personal data by the Buda Health Center. **I was notified by Buda Health Center that its privacy notice is available at its web page (https://www.bhc.hu) and at the scene where it provides medical services.**

1. **Name:** ……………………………………………………………………………………………………………………………………

   **Mother's Name:** ……………………………………………………………………………………………………………………………

   **Address:** ☐☐☐☐ ……………………………………………………………………………………………………………………………

   **Place and Date of Birth:** ……………………………………………………………………………… ☐☐☐☐. ☐☐.☐☐.

   **TAJ No.:** ☐☐☐-☐☐☐-☐☐☐ **Telephone No.:** +36 ☐☐-☐☐☐-☐☐☐☐

2. **Name:** ……………………………………………………………………………………………………………………………………

   **Mother's Name:** ……………………………………………………………………………………………………………………………

   **Address:** ☐☐☐☐ ……………………………………………………………………………………………………………………………

   **Place and Date of Birth:** ……………………………………………………………………………… ☐☐☐☐. ☐☐.☐☐.

   **TAJ No.:** ☐☐☐-☐☐☐-☐☐☐ **Telephone No.:** +36 ☐☐-☐☐☐-☐☐☐☐

3. **Name:** ……………………………………………………………………………………………………………………………………

   **Mother's Name:** ……………………………………………………………………………………………………………………………

   **Address:** ☐☐☐☐ ……………………………………………………………………………………………………………………………

   **Place and Date of Birth:** ……………………………………………………………………………… ☐☐☐☐. ☐☐.☐☐.

   **TAJ No.:** ☐☐☐-☐☐☐-☐☐☐ **Telephone No.:** +36 ☐☐-☐☐☐-☐☐☐☐

4. **Name:** ……………………………………………………………………………………………………………………………………

   **Mother's Name:** ……………………………………………………………………………………………………………………………

   **Address:** ☐☐☐☐ ……………………………………………………………………………………………………………………………

   **Place and Date of Birth:** ……………………………………………………………………………… ☐☐☐☐. ☐☐.☐☐.

   **TAJ No.:** ☐☐☐-☐☐☐-☐☐☐ **Telephone No.:** +36 ☐☐-☐☐☐-☐☐☐☐

Budapest, ……………………………………………… ………………………………………………………………………

*Signature*

BUDAI EGÉSZSÉGKÖZPONT ZRT.

1126 BUDAPEST, KIRÁLYHÁGÓ UTCA 1-3.

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