**“爱目行动”医疗帮扶申请表**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 个人资料填写 | | | | | | | | | | | | |
| 申请人姓名 |  | | 性别 | |  | | | 年龄 | | |  | |
| 身份证号码 |  | | | | 出生日期 | | |  | | | | |
| 联络方式 | 手机: 住宅: | | | | | | | | | | | |
| 户籍地址 |  | | | | | | | | | | | |
| 居住地址 | 同户籍地址 | | | | | | | | | | | |
| 监护人姓名 |  | | 和申请人关系 | | | |  | | | 家庭年总收入  （元） | |  |
| 病况自述 | (发病时间、主要症状、治疗经过、目前情况、相关检查、是否伴有其它疾病…) | | | | | | | | | | | |
| 确诊疾病 |  | | | 确诊医院 | | | | | 医院级别 | | | |
|  | | | | |  | | | |
| 治疗方法/  医生建议 |  | | | | | | | | | | | |
| 备注  (特殊情况及需求) |  | | | | | | | | | | | |
| 签章 | 申请人本人 |  | | | | 申请人之监护人 | | | | |  | |
| 申请时间: 年 月 日  ---申请表请按照实际情况，认真填写--- | | | | | | | | | | | | |