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| м.п. медицинской организации | | | | | | |
| **ЗАЯВКА (коллективная)** | | | | | | |
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|  | **Наименование организации\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
|  | **Адрес организации\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
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| **№  п/п** | **Ф.И.О.** | **УИН участника** | Дата рождения | **пол** | **ступень ГТО** | **Допук врача** |
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|  | Всего в заявке \_\_\_\_\_\_\_\_\_\_\_\_\_человек  Руководитель организации \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  м.п. подпись ФИО  Ответственный\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ контактный телефон\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
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