*Załącznik nr 4a do umowy*   **....….......................................................................**

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Załącznik do rachunku nr …………………./20… na świadczenia medyczne

**LISTA ZREALIZOWANYCH DYŻURÓW**

**za miesiąc …………………………… 20….r.**

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| Dzień m-ca | **ODDZIAŁ INTENSYWNEJ TERAPII***Nazwisko i imię* | Ilość godzin | **ANESTEZJOLOGIA***Nazwisko i imię* | Ilość godzin | **ANESTEZJOLOGIA****DYŻUR** **7.00 – 19.00***Nazwisko i Imię* | Ilość godzin |
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 ***DYREKTOR /PREZES LEKARZ KIERUJĄCY ODDZIAŁEM***

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