Nazwa (firma) ........................................................................

Adres ....................................................................................

Imię i nazwisko .....................................................................

NIP (firma) .............................................................................

Tel. .......................................................................................

**Powiatowa Stacja**

**Sanitarno-Epidemiologiczna**

**w Ciechanowie**

ul. Sienkiewicza 27

06-400 Ciechanów

**WNIOSEK O ZWROT NADPŁATY**

 Proszę o zwrot nadpłaty w kwocie ............................. zł. z dnia ..........................., która powstała w wyniku:

.........................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................

Nadpłatę proszę przekazać na nr rachunku w banku:

.....................................................................................................................................................

(nazwa banku)

Nr rachunku

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

 **.....................................................................**

(podpis wnioskodawcy)

**Wypełnia osoba w Powiatowej Stacji Sanitarno-Epidemiologicznej**