………………………………………………, on: …………………………………..

(Place and date)

**PERSONAL DETAILS OF THE APPLICANT:**

FULL NAME:………………………………………………………………………………………………………

BIRTH DATE:   

*dd mm yyyy*

**CONTACT INFORMATION:**

CURRENT PLACE OF RESIDENCE

**……………………………………………………………………………………………**

STREET, HOUSE/APT. NUMBER

**** **………………………………………………………………**

POSTCODE CITY POSTCODE

⁺ ⁻   

PHONE NO. /OPTIONAL/

**APPLICATION**

**FOR PROVIDING MEDICAL CARE AND GRANTING PROTECTION FOR PERSON UNDER TEMPORARY PROTECTION ON THE TERRITORY OF THE REPUBLIC OF POLAND**

I hereby apply for the provision of medical care and assistance in the form of:

* financial benefits for a person enjoying temporary protection in the territory of the Republic of Poland.

THE APPLICATION ALSO INCLUDES THE FOLLOWING MEMBERS OF MY FAMILY:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NO.** | **FULL NAME** | **DATE OF BIRTH** | **DEGREE OF RELATEDNESS/AFFINITY** | **SYSTEM NO.** |
| **1.** |  |  |  |  |
| **2.** |  |  |  |  |
| **3.** |  |  |  |  |
| **4.** |  |  |  |  |
| **5.** |  |  |  |  |

I hereby declare that I have been informed of the obligation to notify the Head of the Office of Foreigners of any change of address. In the event of failing to act in accordance with that obligation, any official letters issued to the last provided address shall be binding.

…………………………………………………………… ……………………………………………………………

DATE SIGNATURE