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| Nazwa i adres komórki organizacyjnej zakładu leczniczego/praktyki lekarskiej 1) | **ZLK-5****Zgłoszenie podejrzenia lub rozpoznania zgonu**(\*) **z powodu zakażenia lub choroby zakaźnej**2) | Adresat:**Państwowy Powiatowy/Graniczny(**\*) **Inspektor Sanitarny** **w** ........................................................ |
| **Resortowy kod identyfikacyjny podmiotu leczniczego**3)Część I. Numer księgi rejestrowej

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Część II. TERYT

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Część VII. Komórka organizacyjna

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 | **Uwagi**: 1) W przypadku dokumentu sporządzonego w postaci papierowej dane mogą być naniesione na dokumentw formie pieczątki albo nadruku.2) Nie dotyczy zgonów osób zakażonych ludzkim wirusem niedoboru odporności (HIV) i zgonów osóbchorych na zespół nabytego niedoboru odporności (AIDS) – zgłaszanych na innym formularzu.3) Wypełnić zgodnie z rozporządzeniem Ministra Zdrowia z dnia 17 maja 2012 r. w sprawie systemuresortowych kodów identyfikacyjnych oraz szczegółowego sposobu ich nadawania (Dz. U. z 2019 r. poz.173).4) Wypełnić w przypadku, gdy osobie nie nadano numeru PESEL, wpisując serię i numer paszportu albo nazwę, numer identyfikacyjny innego dokumentu, na podstawie którego jest możliwe ustalenie danychosobowych.(\*) Niepotrzebne skreślić. |
| **I . PRZYCZYNA ZGONU/PODEJRZENIE PRZYCZYNY ZGONU**(\*) (należy wpisać każdą przyczynę zgonu, w przypadku gdy w wyjściowej, wtórnej lub bezpośredniej przyczynie zostało wskazane zakażenie lub choroba zakaźna)**1. Data zgonu (**dd/mm/rrrr)

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| **2. Kod ICD-10 3. Określenie słowne:**  |  |  |
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| **II. Dane ZMARłego** **1. Nazwisko**

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**2. Imię 3. Data urodzenia** (dd/mm/rrrr) **4. Nr PESEL**

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**5. Nazwa i numer identyfikacyjny dokumentu**4) **6. Płeć (M, K) 7. Obywatelstwo**

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**8. Kraj urodzenia**

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**9. Osoba bezdomna**

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|  | Tak (w pkt 10–13 podać województwo, powiat, gminę i miejscowość) |  |

**Adres miejsca zamieszkania****10. Województwo 11. Powiat 12. Gmina**

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**13. Miejscowość 14. Kod pocztowy**

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**15. Ulica 16. Nr domu 17. Nr lokalu**

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 |
| **III. DANE ZGŁASZAJĄCEGO LEKARZA/FELCZERA**(wpisać albo nanieśćnadrukiem albo pieczątką) 1. Imię i nazwisko............................................................... ……………. 2. Numer prawa wykonywania zawodu: .................................... 3. Podpis ........................................4. Telefon kontaktowy: ......................................................................... 5. E-mail: ....................................................................... |