MEDICAL CERTIFICATE

The undersigned declares that

Mrs./Miss/Mr.: ……

Born on (date): ……

Resident at (home address): ……

Suffers from a chronic renal insufficiency. The patient performs renal replacement therapy independently by her-/himself by means of a so called peritoneal dialysis or haemodialysis.

In order that the patient is able to continue his treatment during her/his holidays in …..…… she/he needs the below mentioned life saving solution:

Description of solution	**total quantity**
……..	…..……
……..	…..……
……..	…..……

Holiday address: ……

……..

Duration of holiday residence: ……

Total needed amount: ……

Amount per day: ……

Treating Medical Doctor:

Name and Address Hospital:

Signature of the treating medical doctor Date