Centre Hospitalier de Bourg Saint Maurice
Rue du Nantet – BP 11 – 73704 BOURG SAINT MAURICE Cedex
Téléphone : 04 79 41 79 79

CENTRE HOSPITALIER
Bourg Saint Maurice
TARENTAISE

Service de Chirurgie Explorations Fonctionnelles

Tél. : 04 79 41 79 72
Fax. : 04 79 41 79 38

Docteur T. MARTINEZ
Chef de Service
Chirurgie orthopédique
et traumatologique
P.H. temps plein
RPPS : 10003107165

Docteur K. GAMROUDI
PH temps plein
Chirurgie orthopédique
et traumatologique
RPPS : 10100887560

Docteur H. BACHOUR
P.H. temps plein
D.I .S de chirurgie viscérale
D. U. Cœlioscopie
D. U. sensibilisation cancérologie
cutanée
RPPS : 10003099834

Docteur P-N. DUMONT
P.H. temps partiel
D. I. U de Proctologie
D.E.S.C.Q de Chirurgie
viscérale et digestive
RPPS : 10101243797

Docteur R. FONG CHIH KAI
Chirurgie endoscopique
RPPS : 10100944429

Docteur J. KOSACKI
Chirurgie ophtalmologique
RPPS : 10100944429

FFCDS :
Mme METRAL Sandrine
Tel : 04.79.41.79.16

Code identification
730000247

Bourg Saint Maurice, on …../…../…….

Authorization for care: minor patient

Planned date of care: …. / ….. /……

For a minor, **the authorization for care signed by one of the two patients, holders of parental authority or by the legal representative is mandatory** *(article R1112-35 of the Public Health Code).*

Patient's name: ……

Patient's first name(s): ……

Born on: ……

I authorize the medical and paramedical staff of the CH de Bourg Saint Maurice to perform any medical act as well as the nursing care required by the state of health of my minor child during his/her care.

_____

☐ Father ☐ Mother or ☐ Legal Representative

Name: …… First name: ……

Date of birth: …… Phone: ……

Address: ……

Signature:

_____

☐ Father ☐ Mother or ☐ Legal Representative

Name: …… First name: ……

Date of birth: …… Phone: ……

Address: ……

Signature:

_____

Documents to provide: Identity card of one of the parents, holder of parental authority
File created by: