**绿链慈善基金申请表**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 申请人姓名 |  | | 性别 |  | | 出生年月 | | 年 月 日 | | |  |
| 身份证号 |  | | | | | 联系电话 | |  | | |  |
| 通讯地址 |  | | | | | | | | | |  |
| 就诊单位及  科室 |  | | | | | 住院号 |  | | | |  |
| 住院日期 |  | | | | 出院日期 | |  | | | | |
| 总费用 |  | 发票号 | | |  | | | | 申请资助  金额 |  | | |
| 申请理由 | 申请人签名：  日期： | | | | | | | | | | | |
| 治疗病种 | □白内障□青光眼□胬肉□眼底□眼外伤□小儿眼科□角膜移植□其他：  （在对应的□内打“√”） | | | | | | | | | | | |
| 就诊单位意见 |  | | | | | | | | | | | |
| 绿链基金意见 |  | | | | | | | | | | | |