

DIRECCION PROVINCIAL DE SALUD DE SAN CRISTOBAL
PROGRAMA AMPLIADO DE INMUNIZACION (PAI)
VACUNACION A LOS TRABAJADORES DE EMPRESAS O INSTITUCIONES

Area: Departamento Municipal S.L.
Municipio: San Cristobal
LUGAR: Districto Municipal

23/01/18

DATOS DE LOS USUARIOS DEL SERVICIO DE VACUNACION

NOMBRE_APELLIDOS	CEDULA / DOC DE IDENTIDAD (Si es menor del titular)	Fecha / Nac	Edad	SEXO M / F	TIPO DE VACUNAS / DOSIS APLICADAS Y FECHA (DD/MM/AA)						Firma que Avala Vac. y de Consentimiento Informado.				
					dT										
					1ra	2da	3ra	4ta	5ta	Hepatitis B	SR	ANTI-HEPATITIS A	ANTI-TIFOIDI CA	Influenza	
[Handwritten Name]		[Handwritten Date]	[Handwritten Age]	[Handwritten Sex]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]
[Handwritten Name]		[Handwritten Date]	[Handwritten Age]	[Handwritten Sex]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]
[Handwritten Name]		[Handwritten Date]	[Handwritten Age]	[Handwritten Sex]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]
[Handwritten Name]		[Handwritten Date]	[Handwritten Age]	[Handwritten Sex]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]	[Handwritten]
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