Medical Certificate

The undersigned declares that	
Mrs./Miss/Mr.	
born on (date)	
resident at (address)	
suffers from a chronic renal insufficiency.	
The patient performs renal replacement therapy independently by her-/himself by means of a so called abdominal rising	
(Peritoneal Dialysis).	

Purpose
In order that the patient is able to continue this treatment during her/his holidays in :
she/he needs the life saving peritoneal dialysis solutions (product name/description/volume/calcium and glucose concentration):
These solutions are not registered in:
and no comparable solutions are available.

Holiday Details
Holiday address:
Duration of holiday residence
Amount per day:
Totally needed amount:

Any other Information

Treating Medical Doctor	
Name	
Signature and stamp	Date