**STATEMENT**

I, THE UNDERSIGNED PROF. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_-, PhD, Eng., CNP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, HEREBY DECLARE THAT I AM A PATIENT OF THE GENERAL PRACTITIONNER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, MEMBER OF THE NATIONAL HEALTH INSURANCE HOUSE OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COUNTY.

DATE SIGNATURE