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| 様式第３１号（その２）（附則第２項関係） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |
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| 国民健康保険傷病手当金支給申請書（被保険者記入用） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 被保険者氏名 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |
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| 症状が出た日 | | | | | | | 年　　月　　日 | | | | | | | | | | | | | | | | | 帰国者・接触者相談センター  への相談日  ※相談した場合に記入 | | | | | | | | | | | | | | | | | | | | 年　　月　　日 | | | | | | | | | |
| ① | | 医療機関の受診状況 | | | | | | | | | | | | | | | | | | | | | | １　受診した | | | | | | | | | | | | | | | | | | | | ２　受診していない | | | | | | | | | |
| ② | | 医療機関の受診日  （①で「受診した」と回答した場合） | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | 年 | | | |  | | | 月 | |  | | | 日 | |
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| ③ | | 症状（期間などを具体的に）  （①で「受診していない」と回答した場合） | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ④ | | 療養のために休んだ期間 | | | | | | 年　　月　　日から | | | | | | | | | | | | | | | | ⑤ | | | | | 左記期間のうち、勤務ができなかった日数 | | | | | | | | | | | | | | | | | | | | |  |  |  |  |
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|  | | 新型コロナウイルス感染症（発熱等の症状があり感染が疑われる場合を含む。）によらない休暇や勤務予定がなかった日は除く。 | | | | | | | | | | | | | | | | | |  |  | | 日 | |
| 年　　月　　日まで | | | | | | | | | | | | | | | |  | |  |
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| ⑥ | | 上記の療養のために休んだ期間に給与等の支払を受けましたか。  又は、今後受けられますか。 | | | | | | | | | | | | | | | １　はい | | | | | | | | | | | | | | | | | | | | | | | | ２　いいえ | | | | | | | | | | | | |
| ⑦ | | ⑥で「はい」と回答した場合、その給与等の額とその報酬支払の対象となった（なる）期間を記入してください。 | | | | | | | | | | | | | | | 年　　月　　日から | | | | | | | | | | | | | | | | | | | | | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |
|  | | （給与等の額：円） | | | | | | | | | | | |  |
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| 年　　月　　日まで | | | | | | | | | | | | | | | | | | | | | |  | |  |
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| （上記①において「受診していない」と回答した場合は、下記の事業主記載欄について、事業主の証明が必要です。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 事業主記入欄 | | | | 上記③～⑦の内容については、当事業所において把握している内容と相違ないことを証明します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 事業所所在地 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 事業所名称 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | 事業主氏名 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  |  |  |  |  |
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| 担当者氏名 | | | | | | |  | | | | | | | | | | | | | | | | | | | | 電話番号 | | | | | | | | | |  | | | | | | | | | | | | | | | | |