支部様式第12号の２

地方公務員災害補償

文 書 料・室 料 差 額 証 明 書

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| 被災職員氏名 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | 職名 | | | | |  | | | | | | | | | 所属団体名  所属部局名 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 文　　　　　　書　　　　　　料 | | 文書名 | | | | | | | | | | | | | 日付 | | | | | | | | 部数 | | | | | | | 単価 | | | | | | | 金額 | | | | 文書名 | | | | | | | | | | | | 日付 | | | | 部数 | | | | | 単価 | | | | | | 金額 | | | |
| 公務傷病等診断書（認定・障害補償請求時） | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | 円 | | | | | | | 円 | | | | 「療養の現状等に関する報告書」の証明 | | | | | | | | | | | |  | | | |  | | | | | 円 | | | | | | 円 | | | |
|  | | | | 付け | | | |  | | | | | | |  | | | | | | |  | | | |  | | 付け | |  | | | | |  | | | | | |  | | | |
| 医学的意見書 | | | | | | | | | | | | |  | | | | | | | |  | | | | | | |  | | | | | | |  | | | | 「傷病の現状報告書」 | | | | | | | | | | | |  | | | |  | | | | |  | | | | | |  | | | |
| 室料差額必要証明 | | | | | | | | | | | | |  | | | | | | | |  | | | | | | |  | | | | | | |  | | | | 死亡診断書 | | | | | | | | | | | |  | | | |  | | | | |  | | | | | |  | | | |
| 「同意書」の証明 | | | | | | | | | | | | |  | | | | | | | |  | | | | | | |  | | | | | | |  | | | | 死体検案書 | | | | | | | | | | | |  | | | |  | | | | |  | | | | | |  | | | |
| 「看護証明書」の証明 | | | | | | | | | | | | |  | | | | | | | |  | | | | | | |  | | | | | | |  | | | | その他（ | | | | |  | | | | |  | |  | | | |  | | | | |  | | | | | |  | | | |
| 「移送費証明書」の証明 | | | | | | | | | | | | |  | | | | | | | |  | | | | | | |  | | | | | | |  | | | |  | | | | | | | | | | | |  | | | |  | | | | |  | | | | | |  | | | |
| 「休業補償請求書」の証明 | | | | | | | | | | | | |  | | | | | | | |  | | | | | | |  | | | | | | |  | | | |  | | | | | | | | | | | |  | | | |  | | | | |  | | | | | |  | | | |
| 治療材料等の支給証明 | | | | | | | | | | | | |  | | | | | | | |  | | | | | | |  | | | | | | |  | | | |  | | | | | | | | | | | |  | | | |  | | | | |  | | | | | |  | | | |
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| 室　　　　料　　　　差　　　　額 | 入院期間 | | | | | | | | |  | | | | | | | | | |  | | | | 年 | | | |  | | | | 月 | | | |  | | | 日から | | | | | |  | | | 年 |  | | | 月 | |  | | | | 日まで | | | | |  | | 日間 | | | | | | |
| 差額室使用期間 | | | | | | | | |  | | | | | | | | | |  | | | | 年 | | | |  | | | | 月 | | | |  | | | 日から | | | | | |  | | | 年 |  | | | 月 | |  | | | | 日まで | | | | |  | | 日間 | | | | | | |
| 差額室必要期間 | | | | | | | | |  | | | | | | | | | |  | | | | 年 | | | |  | | | | 月 | | | |  | | | 日から | | | | | |  | | | 年 |  | | | 月 | |  | | | | 日まで | | | | |  | | 日間 | | | | | | |
| 上級室個室等を必要とした理由（いずれか該当する項目に○印をしてください）  （医師記載のこと） | | | | | | | | | ア　療養上他の患者から隔離しなければ適切な診療を行うことができなかった。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| イ　傷病の状態から隔離しなければ他の患者の療養を著しく妨げるおそれがあった。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ウ　普通室が満床でかつ、緊急に入院療養させる必要があった。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| エ　その他（具体的かつ詳細に記入してください） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 傷病名 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 室 料 差 額 に 係 る 入 院 期 間 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 室 の 種 類 | | | | | | | | | | | | | | | | | | | 単価 | | | | | 金額 | | | | | |
|  | |  | 年 | | |  | | 月 | | |  | 日から | | | | | | | |  | | | | 年 | |  | | | | 月 | |  | | 日 | | |  | | 日間 | | 個室　 　上級室　 　その他 | | | | | | | | | | | | | |  | | |  | |  | | | | |  | | | | | |
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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | Ｂ　室料差額合計 | | | | | | | | |  | | | | | | | | | | | | | | 円 | |
| そ　の　他 | 名　　　　　　　　　　　　　　　　　　　　　　　　　　　　　称 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 数量 | | | | | 単価 | | | | | | 金額 | | | | |
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| （注）この欄には上記以外のもので診療報酬点数表により計算できないものを記載する | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Ｃ　その他合計 | | | | | | | | |  | | | | | | | | | | | | | | | 円 |
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| 地方公務員災害補償基金千葉県支部長　様  　上記のとおりであったことを証明します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 医療機関 | | | | | | | | | | | | | | | | 医療機関名 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | 医師の氏名 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

（注）１．診断書は認定請求時の１通のみ支払います。他の診断書については被災職員の負担となります。

なお、障害補償請求時の診断書については、別に１通分支払います。

２．この様式は、下記医療機関で使用してください。

記

独立行政法人国立病院機構の病院・千葉労災病院・千葉大学医学部附属病院・習志野病院・成田赤十字病院・県立病院・



市立病院・国保病院