支部様式第11号の３（柔道整復師用）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 療 養 補 償 請 求 書 | | | | | | | | | | | | | | | | | | | 認定番号 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 請求回数 | | | | 第 | | | | | |  | | | | | | | | | | | | | | | 回 | | | |
| 地方公務員災害補償基金千葉県支部長　様 | | | | | | | | | | | | | | | | 請求年月日 | | | | | | | | |  | | 年 | | | | | |  | | | | 月 | | |  | | | | 日 | | | |
| 請求者の住所 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 下記の療養補償を請求します。 | | | | | | | | | | | | | | | |
| ふりがな | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 氏　　　　名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| １　補償費用の受領委任 | この請求書による療養補償の費用の受領を | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | に委任します。 | | | | | | | | | | | | | | | | | |
| 委任者の氏名 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 上記委任に基づき、この請求書による療養補償の費用の支払を請求します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 受任者の住所 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 名　　　　称 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| 氏　　　　名 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ２ | 所属団体名 | | | | | | | | | | | | | | | | | 所属部局名 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 被災職員に 関する事項 |
| 氏　　　名 | | | | | | | | | | | | | | | | | 職　　　名 | | | | | | | | | | | | | | | | 常　　　　勤 | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | 令第１条職員 | | | | | | | | | | | | | |
| 負傷又は発病の年月日 | | | |  | | | |  | | | | | 年 | | | |  | | | 月 | | |  | | | | 日 | | |
|  | | 年 | |  | 月 | | |  | 日生（ | |  | | 歳） | | | |
| ３　施　術　料 | | | | 内訳は「５施術料の内訳」欄記載のとおり | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | 円 | |
| ４　送金先 | | 振込先銀行 | | | | |  | | | | 銀行 | |  | | | | 支店 | | | ※受　　理 | | | |  | | | |  | | | | 年 | | | |  | | | 月 | | |  | | | | 日 | |
| 普通預金　　　当座預金 | | | | | | | | | | | | | | | | | | ※決定金額 | | | |  | | | | | | | | | | | | | | | | | | | | | | 円 | |
| 口座番号 | | | | | |  | | | | | | | | | | | | ※通　　知 | | | |  | | | |  | | | | 年 | | | |  | | | 月 | | |  | | | | 日 | |
| ふりがな | | | | | |  | | | | | | | | | | | | ※支　　払 | | | |  | | | |  | | | | 年 | | | |  | | | 月 | | |  | | | | 日 | |
| 預金名義 | | | | | |  | | | | | | | | | | | |
| （預金名義は省略せずに通帳の記載どおりに記入してください。） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

注１　柔道整復師の方へ……



(1) この請求書は、千葉県柔道整復師会との協定に基づき、公務上又は通勤により負傷し、又は疾病にかかった地方公務員が 施術を受ける際使用するもので、施術に要した費用は、受領委任の方法により地方公務員災害補償基金千葉県支部から 口座振替の方法により直接支払いますので、本人には請求しないでください。

(2) この請求書は、被災職員別に作成し、月ごとに翌月の10日までに、〒260-0843　千葉市中央区末広３－２１－６

千葉県柔道整復師会に提出してください。

(3) 施術料金は協定料金により支払います。

注２　被災職員の方へ……

(1) この請求書は、千葉県柔道整復師会に所属する柔道整復師で施術を受ける場合のみ使用してください。

(2) この請求書は、初診日及び療養を継続している場合には毎月20日ごろまでに、柔道整復師に必ず提出してください。

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ５．施 術 料 の 内 訳 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ( | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | 年 | | | | | |  | | | 月分) | | |
| 負傷名 | | | | | | (1) |  | | | | | | | | | | | | | | | | | | | | | (2) | |  | | | | | | | | | | | | | | | | | | | | | | | (3) | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 負傷年月日 | | | | | | (1) |  | | | | | |  | | 年 | |  | | 月 | |  | | 日 | | |  | | (2) | |  | | |  | | 年 | |  | | 月 |  | | 日 | | | | |  | | | | | | (3) | | | | | |  | | | | | | | | | | | | | | |  | | | | | 年 | | | | | |  | | | 月 |  | | 日 |  |
| 施術期間 | | | | 自  至 | | (1) |  | | 年 | | | |  | | 月 | |  | | 日 | | 施術日数 | | | | | | | (2) | |  | | 年 |  | | 月 | |  | | 日 | 施術日数 | | | | | | | | | | | | | (3) | | | | | |  | | | | | | | 年 | | | | | | | |  | | | | | 月 | | | | | |  | | | 日 | 施術日数 | | | |
|  | | 年 | | | |  | | 月 | |  | | 日 | | ( | |  | | | 日) | |  | | 年 |  | | 月 | |  | | 日 | ( | |  | | | | | 日) | | | | | |  | | | | | | | 年 | | | | | | | |  | | | | | 月 | | | | | |  | | | 日 | ( | |  | 日) |
| 負傷の原因 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 負傷の経過 | | | | | | (1) |  | | | | | | | | | | | | | | | | | | | | | (2) | |  | | | | | | | | | | | | | | | | | | | | | | | (3) | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 転帰 | | | | | | (1) | 治ゆ・中止・転医・継続 | | | | | | | | | | | | | | | | | | | | | (2) | | 治ゆ・中止・転医・継続 | | | | | | | | | | | | | | | | | | | | | | | (3) | | | | | | 治ゆ・中止・転医・継続 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 施　　術　　の　　内　　訳　　及　　び　　金　　額 | | 初　検　料 | | | | 基 本 初 検 料 | | | | | | | | | | | | | | | | | | | | |  | | 万 | | 千 | | | 百 | | 十 | | 円 | | | 施術を行った期間 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 備　考 | | | | | | |
|  | |  | |  | | |  | |  | |  | | |  | | | | 年 | | | | |  | | | | | | | 月 | | | | | | |  | | | | | | | | 日　時頃 | | | | | | | | | | | | | |
| 加算 | | | | 時間外・休日・深夜 | | | | | | | | | | | | | | | | |  | |  | |  | | |  | |  | |  | | |  | | | | | | |
| 再　検　料 | | | |  | | | | | | | | | | | | | | | | | | | | |  | |  | |  | | |  | |  | |  | | |  | | | | | 月 | | | | | | | | | | | |  | | | | | | | | | 日 | | | | | | | | | | | | | | | | | | |  | | | | | | |
| 指導管理料 | | | |  | | | | | | | | | | | | | | | | | | | | |  | |  | |  | | |  | |  | |  | | |  | | | 月 | | | | |  | | | | | | | 日・ | | | | | | | | |  | | | | | | | | 月 | | | | |  | | | | | | 日 | |  | | | | | | |
| 往　療　料 | | | |  | | | | | | | km | | | |  | | | | | | | | | 回 | |  | |  | |  | | |  | |  | |  | | |  | | | | | | | | | | 月 | | | | | | | | |  | | | | | | | | | | 日から | | | | | | | | | | | | | | | |  | | | | | | |
| 夜間・難路・暴風雨雪・ | | | | | | | | | | | | | | | | |  | | | 回 | |  | |  | |  | | |  | |  | |  | | |  | | | | | | | | | | 月 | | | | | | | | |  | | | | | | | | | | 日まで | | | | | | | | | | | | | | | |  | | | | | | |
|  | | | | 回　　　数 | | | | | | | | | １回の料金 | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| 整　復　料 | | | | (1) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | | | | | | | | | | | | 月 | | | | | | |  | | | | | | | | | | | | | | 日 | | | | | |  | | | | |  | | | | | | |
| 固　定　料 | | | | (2) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | | | | | | | | | | | | 月 | | | | | | |  | | | | | | | | | | | | | | 日 | | | | | |  | | | | |  | | | | | | |
| 施　療　料 | | | | (3) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | | | | | | | | | | | | 月 | | | | | | |  | | | | | | | | | | | | | | 日 | | | | | |  | | | | |  | | | | | | |
|  | | | | (1) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | |  | | | | | | |
| 後　療　料 | | | | (2) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | |  | | | | | | |
|  | | | | (3) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | |  | | | | | | |
|  | | | | (1) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | |  | | | | | | |
| 電　療　料 | | | | (2) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | |  | | | | | | |
|  | | | | (3) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | |  | | | | | | |
|  | | | | (1) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | |  | | | | | | |
| 罨　療　料 | | | | (2) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | |  | | | | | | |
|  | | | | (3) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | |  | | | | | | |
| 特　別　加　算 | | 初検時 | | (1) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | | | | | | | | | | | | 月 | | | | | | |  | | | | | | | | | | | | | | 日 | | | | |  | | | | | |  | | | | | | |
| (2) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | | | | | | | | | | | | 月 | | | | | | |  | | | | | | | | | | | | | | 日 | | | | |  | | | | | |  | | | | | | |
| (3) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | | | | | | | | | | | | 月 | | | | | | |  | | | | | | | | | | | | | | 日 | | | | |  | | | | | |  | | | | | | |
| 後療時 | | (1) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | | |  | | | | | | |
| (2) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | | |  | | | | | | |
| (3) | | |  | | | 回 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | | |  | | | | | | |
| 入　室　料 | | | |  | | | | | | 日 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | | |  | | | | | | |
| 食　事　料 | | | |  | | | | | | 食 | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | 月 | | | | |  | | | | | | | 日から | | | | | | |  | | | | | | 月 | | | | | | | |  | | | | | | 日まで | | | |  | | | | | | |
| 証明書料 | | | |  | | | | | | | | |  | | | |  | |  | | | |  | | |  | |  | |  | | |  | |  | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| そ　の　他 | | | |  | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |
|  | 請　　求　　金　　額 | | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | | |  | |  | |  | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | |

注　１．該当するところには○印で表示してください。

　　２．負傷の経過はなるべく具体的に記入してください。

　　３．レントゲン診断が行われた場合はＸ線照射録を添付してください。