様式１６－２

感染救済給付用

**葬祭料請求書**

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| ⑴ | フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | 男  女 | | | | | ⑵ |  | | | | 明治  大正  昭和  平成  令和 | | | | | |  | 年 |  | | | | 月 | | |  | | | 日 | | | |  | | | 歳 | | | |
|  | 請求者の氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | 生年月日  及び年齢 | | | | |
| ⑶ | フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 電　話 | | | | | | | | | | | | | | | | | | | | | |
|  | 現　住　所 | | | | | ( 〒 | | | | | |  | | － | | | |  | | | | | ) | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | ( | |  | | | | | | | | ) | | |  | | | | |
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| ⑷ | 死亡者との身分関係 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ⑸ | フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | 男  女 | | | | | ⑹ |  | | | | 明治  大正  昭和 平成  令和 | | | | | |  | 年 |  | | | | 月 | | |  | | | 日 | | | |  | | | 歳 | | | |
|  | 死亡者の氏名 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | 生年月日  及び年齢 | | | | |
| ⑺ | フリガナ | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ⑻ | | |  | | | 平成  令和 | | |  | 年 | | | |  | | | | | 月 | | | |  | | | | | 日 |
|  | 死亡者が死亡の当時有していた住所 | | | | | ( 〒 | | | | | |  | | － |  | | | | | | ) | | |  | | | | | | | | | | | | | | | | | | 死亡 年月日 | | | | | |
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| ⑼ | 死亡の当時診療を受けていた医療機関の名称及び所在地 | | | | | | | 医療機関の名称 | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 所在地 | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ⑽ | 死亡の原因となった生物由来製品等を介した感染等によるものとみられる疾病の名称又は症状 | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (10-1)⑽の疾病による死亡の原因とみられるもの | | | | | | | | | | | | | | | | | | | | | | | | | | | 生物由来製品・再生医療等製品・2次感染等 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2次感染等  の場合 | | | (10-2) | | | | | | | フリガナ | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1次感染者の氏名 | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (10-3)請求者と(10-2)の者との身分関係 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 配偶者・親族・その他( | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | ) | |
| (10-4)(10-2)の者の感染救済給付の有無 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 有 (受給者番号： | | | | | | | | | |  | | | | | | | | | | | | | | | | | | )・無 | | | | | | | | | | | |
| ⑾ | 死亡の原因とみられる生物由来製品等とその入手・使用場所 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 生物由来製品等の名称 | | | | | | | | | 医療機関等の名称 | | | | | | | | | | | | | | | | | | | | 所在地 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ⑿ | 遺族の状況 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 氏　名 | | | | | 生年月日 | | | | | | | | | | | | | | | | | | | | | | | | | ⑸の死亡者と  の身分関係 | | | | | | 現住所 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | 明・大・昭  平・令 | | | | | | | | | | | |  | | ・ | | |  | | | | ・ | |  | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | 明・大・昭  平・令 | | | | | | | | | | | |  | | ・ | | |  | | | | ・ | |  | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | 明・大・昭  平・令 | | | | | | | | | | | |  | | ・ | | |  | | | | ・ | |  | |  | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ⒀ | 請求者が葬祭を行う年月日又は行った年月日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 平成  令和 | | | |  | | 年 | | |  | | 月 | | |  | | | 日 | | | | | | | | | | | | | | | | | | | | | | | | |
| ⒁ | ⑽の疾病について当機構からの医療費・医療手当の受給の有無 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 有 (受給者番号： | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | )・無 | | | | | | | | |
| ⒂ | ⑽の疾病について当機構からの障害年金又は障害児養育年金の受給の有無 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 有 (受給者番号： | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | )・無 | | | | | | | | |
| ⒃ | ⑾の生物由来製品等による副作用救済給付の有無 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 有 (受給者番号： | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | )・無 | | | | | | | | |
| ⒄ | 死亡又は⑽の疾病について訴訟又は示談の有無 | | | | | | | | | | | | | | | | | | | | | | | | | | | | 有 ( 刑事事件　民事事件　和解　示談 )・無 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ⒅ | 救済制度に関する情報の入手経路について | | | | | | | | | | | | | | | | | | | | | | | | | | | | 医師　歯科医師　薬剤師　その他の医療機関職員 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 新聞・TV等　その他( | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | ) | | |
| 上記のとおり、請求に係る葬祭料の支給を受けたく、必要書類を添えて請求します。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 令和 | |  | | 年 | | |  | | | | 月 | |  | | | 日 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 請求者氏名 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| 独立行政法人　医薬品医療機器総合機構　理事長　殿 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

救済給付に係る情報（請求者の個人情報を除く。）は、「医薬品、医療機器等の品質、有効性及び安全性の確保等に関する法律」第68条の10第3項の規定に基づき、安全対策に利活用されますので、予めご了承下さい。