



**Medical treatment for former cross-border worker
in former country of work**

3. INSTRUCTIONS COMPLETING THE FORM

3.1 Name	
3.2 Street, N°	
3.3 Town	
3.4 Post code	3.5 Country code
3.6 Institution ID	
3.7 Office fax N°	
3.8 Office phone N°	
3.9 E-mail	
3.10 Date	
3.11 Signature	

Stamp area:
