**Application for Contribution to Medical Devices, Medicinal Products, and other assortment of pharmacies for the purpose of protecting and promoting health and preventing diseases**

First and last name:

Workplace:

Sodexo Multi Pass CARD / Pluxee CARD: [ ]  I have [ ]  I don´t have

Please note: the allowance can only be granted if the old balance on the benefit card for a pharmacy purchase is no more than CZK 299.

**Affidavit:**

I hereby declare that in the year       I did not draw any contribution to healthcare, and I did not apply for this contribution at any other integral part of the university.

By signing this request, I declare that I agree that the employer will collect my personal data for the purpose of declaration and granting the reimbursement of costs for professional progress and that the employer can handle and process them for the same propose according to the provisions of law No. 110/2019 Sb. concerning the protection of personal data, as amended.

Date:       Employee’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Statement by the personnel office:** [ ]  complies [ ]  does not comply

Date of commencement of employment at FSV: \_\_\_\_\_\_\_\_\_\_\_\_

Workload coefficient: \_\_\_\_\_\_\_\_\_\_

Amount of contribution: \_\_\_\_\_\_\_\_\_\_\_\_CZK

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Head of the Personnel Department: Budget Supervisor:**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Delivered to the Account Office for reimbursement:**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_