**REQUEST OF SERVICES TO THE CYTOMICS UNIT**

*For the Hospital U. i P. La Fe*

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|  | **Nº APPLICATION:** |       |
| **APPLICANT DETAILS** |
| Date of Request:  |       |
| Applicant name:  |       |
| Unit’s responsible:  |       |
| Unit/Service:  |       |
| Phone:  |       |  Mobile:  |       | E-mail:  |       |
| **BILLING DATA** |
| CIF:  | S-4611001-A | Fiscal Name:  | Hospital Universitario y Politécnico La Fe |
| Address:  | Avda. Fernando Abril Martorell, 106 |
| Province: | Valencia | City: Valencia | Postal Code: 46026 |
| Contact of the Administration Dept.:  |  |
| Phone:  |  | Email: |  |
| **REQUESTED SERVICE** |
| **CODE** | **DESCRIPTION** | **PRICE** |
|       |       |       **€** |
|       |       |       **€** |
| **TOTAL BUDGET** *(IVA not included)* |       **€** |
| I request the service indicated above, in the case of modification of the application, a complementary request will be made, if necessary |
| **PATIENT'S DATA** *(this form should not include patient data other than those listed below)* |
| Acronym of the patient:  |       | SIP: |       |
| **Signature of the applicant** | **Signature and seal of Director of the Area or Chief of the Service** | **Vº Bº Economic Direction Dept. of Health Valencia La Fe** | **Acceptance byCytometry Unit** |
| Name:Date: | Name:Date: | Name:Date:  | Name: Date: |