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|  | **DIAGNÓSTICO** |

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| |  | | --- | | FECHA DE EMISIÓN: | | | | | | | | | | | | | FechaDeEmicionTemplate | | | | | | | | | | | | | | |  |  |  |  | | | | |  |
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|  | | |  | | |  |  |  | |  | | --- | | **DIAGNÓSTICO PROGRAMA RECUPERACIÓN DENTAL JUBILADOS** | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |
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| NOMBRE | | | | | | NombreTemplate | | | | | | | | | | | | | | | | | | | | |  | ID: | IdTemplate | | | | |  |  |
| RUT | | | | | | RutTemplate | | | | | | | | | | | | | | | | | | | | |  |  |  | | | | |  |  |
| EDAD | | | | | | EdadTemplate | | | | | | | | | | | | | | | | | | | | |  |  |  | | | | |  |  |
| F. NAC. | | | | | | FechaDeNacimientoTemplate | | | | | | | | | | | | | | | | | | | | |  |  |  | | | | |  |  |
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| |  | | --- | | Estimado/a: Usted es beneficiario/a del Programa de Recuperación Dental para ex trabajadores de Empresas Socias de la Cámara Chilena de la Construcción.  Esta etapa del programa social considera las siguientes prestaciones, a un costo de $9.990:   * RADIOGRAFÍAS * DIAGNÓSTICO * HIGIENE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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|  | | | |  |  |  | | --- | --- | --- | | COMUNA | PRESTADOR | DIRECCIÓN | | SANTIAGO | REDSALUD MANUEL MONTT | AVENIDA PROVIDENCIA #1346, PROVIDENCIA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| |  | | --- | | AL MOMENTO DE LA ATENCIÓN, DEBE PRESENTAR SU CÉDULA DE IDENTIDAD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| |  | | --- | | **\*Esta carta es personal e intransferible. Está estrictamente prohibido ceder a otra persona.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |

**Nicolás Sanhueza.**

**Subgerente Programas de Salud.**

**Fundación Cámara Chilena de la Construcción.**