**ZAŁĄCZNIK NR 1 DO UMOWY NR ........../2025 ZA MIESIĄC ……….. 2025**

 na udzielanie świadczeń zdrowotnych w zakresie…………….……………………………

Nazwa Komórki Organizacyjnej: ……………………………….., Wojewódzki Szpital Specjalistyczny Nr 4 w Bytomiu.

**…………………………………………………………**

**(Imię i Nazwisko)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ………………………………….. 2025 |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | GODZINY | GODZINY WYKONANE | UWAGI |  |  | GODZINY | GODZINY WYKONANE | UWAGI |  |  |  |  |  |  |  |  |  |  |  |  |  |
| OD | DO | OD | DO |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1 |  |  |  |  | 17 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  | 18 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  | 19 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  | 20 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  | 21 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  | 22 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  | 23 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  | 24 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  | 25 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10 |  |  |  |  | 26 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11 |  |  |  |  | 27 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12 |  |  |  |  | 28 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13 |  |  |  |  | 29 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14 |  |  |  |  | 30 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16 |  |  |  |  | **RAZEM GODZIN : h min=h** |

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Podpis i pieczątka Kierownika Oddziału/ Pielęgniarki Oddziałowej Podpis i pieczątka przyjmującego zamówienie

 potwierdzającego liczbę godzin wykonanych

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 Podpis pracownika Działu Kadr i Płac