様式第１号

**療育手帳再判定申請書**

　　　　令和　　年　　月　　日

長崎県知事　様

療育手帳の再判定を下記のとおり申請します。

　　　　　申請者　　　　　　　　　　　　　　　　　　（続柄　　　　　）

　　◇再判定の理由（該当するものに○を）

　　　　１　再判定時期の到来（　　　　　年　　　月）

　　　　２　障害程度の変化

　　　　３　その他（　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 療育手帳番号 | | | | | | |  | | | | |  | | |  | | | | |  | | | | | |  | | | | 障害程度 | | | | |  | | | **＊太枠の中を記入下さい。** | | | | | | | |
| 本  人 | フリガナ | | 姓 | | | | | | | | | | | | | | | | | | | | 名 | | | | | | | | | | | | 男・女 | | 生 年 月 日 | | | | | | | | |
| 氏名 | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | 年　　月　　日 | | | | | 歳 | |
| 個人番号 | |  | | | | | | |  | | | | | |  | | | | | | | | |  | | | | | | |  | |  | |  | |  | |  |  | |  | |  |
| 住所 | | 〒 | | |  | | |  | | |  | | － | | | |  | | |  | | |  | | | |  | | | 電話（　　　　　）　　　　－ | | | | | | | | | | | | | | |
| 市  　　　　　　　　町 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 施設を利用  中の場合 | | | 施設名 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 保  護  者 | フリガナ | 姓 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 名 | | | | | | | | | 続柄 | | | |
| 氏名 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | |
| 住所 | 〒 | | |  | | |  | | |  | | － | | | |  | |  | | |  | | | | |  | | 電話（　　　　　）　　　　－ | | | | | | | | | | | | | | | | |
| 市  　　　　　　　　町 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| 支所受付印 | 市町受付印 | 判定機関受付印 |
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| 台帳管理 | 市・町 |

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| 通信欄： |