###### DENÚNCIA

PROTOCOLO Nº

RECEBIDO EM\_\_\_/\_\_\_/\_\_\_

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| **Dados do Denunciante** |
| Nome Completo:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sexo: \_\_\_\_\_\_\_\_ Data de Nascimento: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Estado Civil: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Nacionalidade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Profissão: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CPF/CNPJ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Identidade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Órgão expedidor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Data de Exp..:\_\_\_\_\_\_\_  Endereço:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_n.º \_\_\_\_\_\_\_  Complemento:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bairro:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cidade:\_\_\_\_\_\_\_\_\_\_\_\_\_ Estado:\_\_\_\_\_\_\_\_\_\_ CEP.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telefones: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_- ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  E-mail Pessoal:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Dados do Paciente ( ) o Próprio ( ) Terceiros** |
| Nome Completo:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sexo: \_\_\_\_\_\_\_\_ Data de Nascimento: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Estado Civil: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Nacionalidade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Profissão: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CPF/CNPJ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Identidade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Órgão expedidor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Data de Exp..:\_\_\_\_\_\_\_  Endereço:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_n.º \_\_\_\_\_\_\_  Complemento:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bairro:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cidade:\_\_\_\_\_\_\_\_\_\_\_\_\_ Estado:\_\_\_\_\_\_\_\_\_\_ CEP.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telefones: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_- ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Rubrica do Denunciante

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| **Dados da Ocorrência** |
| Óbito do paciente: ( ) sim ( ) não Data do óbito: \_\_\_\_/\_\_\_\_/\_\_\_  Data do Fato: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  Local do Fato: ( ) Consultório ( ) Hospital ( )Clínica ( ) Laboratório ( ) Outros  Nome da Instituição: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Endereço: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_n.º \_\_\_\_  Complemento: \_\_\_\_\_\_\_\_ Bairro: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cidade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Estado: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CEP.:\_\_\_\_\_\_\_\_\_\_\_\_\_ Telefones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Denunciados** |
| Nome:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CRM: \_\_\_\_\_\_  Nome:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CRM:\_\_\_\_\_\_  Nome:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CRM: \_\_\_\_\_\_  Nome:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CRM:\_\_\_\_\_\_ |

Declaro estar ciente de que os autos tramitam em sigilo processual, conforme Art. 33, *parágrafo único* da RESOLUÇÃO CREMERJ nº 324/21 e comprometo-me, sob as penas da lei, a não divulgar ou dar publicidade às referidas peças.

Declaro que todas as informações fornecidas são verdadeiras e assumo inteira responsabilidade pelas mesmas, assim como estou ciente que tenho a obrigação de manter meus dados atualizados.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(local e data)

Assinatura do Denunciante

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| Relato dos Fatos. |

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