



FNOMCeO

Prot. N°: \_\_\_\_\_

Rif. Nota:

Resp. Proced.: - Dr.ssa L. Castigliero

Resp. Istrut.:

OGGETTO:

Registro Italiano dei Medici – nuova  
Iniziativa.

Roma, \_\_\_\_\_

COMUNICAZIONE N. 86

AI PRESIDENTI DEGLI ORDINI PROVINCIALI  
DEI MEDICI CHIRURGHI E DEGLI  
ODONTOIATRI

AI PRESIDENTI DELLE COMMISSIONI PER  
GLI ISCRITTI ALL'ALBO DEGLI  
ODONTOIATRI

LORO SEDI

Ci è giunta una segnalazione concernente una nuova iniziativa, a nome della "EuroMedi\* - European Medical Directory" la quale, dall'esame della documentazione pervenuta, che alleghiamo, appare del tutto simile alla ben nota richiesta di "aggiornamento dati" del Registro Italiano dei Medici.

E' necessario, pertanto, prestare la massima attenzione in caso di ricevimento di tale modulistica, evitando di sottoscriverla.

Si prega di dare massima diffusione a tutti gli iscritti.

Cordiali saluti

IL PRESIDENTE  
Dott.ssa Roberta Chersevani



All.to

2016/10450-20-09-2016-PARTENZA

MD16027 1761066920

ROBERTO CASIERI  
PAPA GIOVANNI PAOLO  
SOCIETA' ITALIANA  
ITALY

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Dept. Database/Data Verification

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Your reference:

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Our reference:

II MD230-140-042016/10-001

Date: 20 April 2016

Please read carefully.

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**03 June 2016**

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MEDICAL SPECIALTY, MAIN FOCUS
INFECTIOUS DISEASES
Reg. number

PRACTICE DETAILS
Tick as appropriate <input checked="" type="checkbox"/>
Opening hours
Location and accessibility
<input type="checkbox"/> Ground floor <input type="checkbox"/> Elevator <input type="checkbox"/> Parking space
<input type="checkbox"/> Wheelchair access <input type="checkbox"/> _____
Spoken languages
<input type="checkbox"/> German <input type="checkbox"/> English <input type="checkbox"/> Spanish
<input type="checkbox"/> _____

ADDITIONAL INFORMATION
Appointments <input checked="" type="checkbox"/>
<input type="checkbox"/> By telephone <input type="checkbox"/> Online <input type="checkbox"/> Email
<input type="checkbox"/> By arrangement
Home visits    Acceptance of emergency patients
<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
Equipment
<input type="checkbox"/> Ultrasonic <input type="checkbox"/> ECG <input type="checkbox"/> EEG
<input type="checkbox"/> Endoscopy <input type="checkbox"/> Laser <input type="checkbox"/> _____

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