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| **NOMBRE:** |  | | |
| **SEGURO SOCIAL:** |  | **REEMBOLSO DE APORTACIONES:** |  |
| **RECOMENDACIONES:** | Incapacidad Total y Permanente | | |
| Enfermedad Terminal | | |
| No Cumple con los Requisitos de la Ley 447 | | |
| Se recomienda Tutor. | | |
| **OBSERVACIONES:** | | | |
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| **LICENCIA** |  | **NOMBRE DEL CONSULTOR MÉDICO** |
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| **FECHA (día/mes/año)** |  | **FIRMA** |

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| **NOMBRE:** | |  | | | **SEGURO SOCIAL:** |  | |
| **OBSERVACIONES (Continuación):** | | | | | | | |
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| **LICENCIA** | |  | | **NOMBRE DEL CONSULTOR MÉDICO** | |
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| **FECHA (día/mes/año)** | |  | | **FIRMA** | |