**附件6**

**医疗发票汇总表**

困难职工姓名： 工作单位：

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 序号 | 医疗发票日期 | 发票总金额 | 个人支付金额 | 备注 |
| 1 |  |  |  |  |
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| **合 计** |  |  |  |

基层工会填报人： 填报日期：