

Stamp of the Clinic or Hospital

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Date

## Certificate for the travelling patient with Cystic Fibrosis\*

(\* PL: mukowiscydoza, FR: fibrose kystique, ES: fibrosis quística, DE: Mukoviszidose, RU: муковисцидоз, UK: муковіцидоз, CS/SK: cystická fibróza)

Ms/Mr .....

born on: .....

has Cystic Fibrosis and is treated with:

1. ....
2. ....
3. ....
4. ....
5. ....
6. ....
7. ....
8. ....

and need the following medicinal products and devices that are necessary for treatment:

inhaler .....

portable handheld inhaler .....

nebulizer .....

portable oxygen concentrator (POC) .....

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Physician's stamp and signature