

## Instructions for completing

### The declaration of choice of physician, nurse, and midwife in primary healthcare for both women and men, prepared by NZOZ ŚW.PWŁA 11A.

Follow the instructions below:

- If you are Man download the document labeled '03'.
- If you are a woman download the document labeled '04'.
- Save it on your computer and print it.
- Then, complete the **03 (if you are man)**, or **04 (If you are a woman)** document in the correct order according to the following instructions.
- The instructions contain **3 PARTS**:
  - **Men** should fill out: **PART 1**(DECLARATION OF CHOICE OF A HEALTHCARE PROVIDER PROVIDING PRIMARY HEALTHCARE SERVICES, INCLUDING A PRIMARY HEALTHCARE PHYSICIAN), and **PART 2**(DECLARATION OF CHOICE OF A HEALTHCARE PROVIDER PROVIDING PRIMARY HEALTHCARE SERVICES, INCLUDING A PRIMARY HEALTHCARE NURSE).
  - **Women** should fill out: **PART 1, PART 2** and **PART 3**(DECLARATION OF CHOICE OF A HEALTHCARE PROVIDER PROVIDING PRIMARY HEALTHCARE SERVICES, INCLUDING A PRIMARY HEALTHCARE MIDWIFE)
- The instructions contain numbered fields such as 1, 2, 3... 5A, 5B... 12, 13, etc., which correspond to the Polish version of the document.
- You must complete the Polish version of the Declaration of Choice of Physician and Nurse or Midwife (**if you are a woman**) following the instructions provided in English.

#### **PART 1. DECLARATION OF CHOICE OF A HEALTHCARE PROVIDER PROVIDING PRIMARY HEALTHCARE SERVICES, INCLUDING A PRIMARY HEALTHCARE PHYSICIAN**

##### **I. PATIENT INFORMATION**

1. Name
2. Surname
3. Date of Birth
4. Personal Identification Number, In the absence thereof, provide the series and number of the identity confirming document
5. Residential Address.
  - 5A. Street
  - 5B. House/Apartment Number
  - 5C. Postal Code and City
6. Phone Number (Optional Field)
7. Email Address (Optional Field)

8. Information Regarding the Legal Representative (in case the recipient of services is a minor or legally incapacitated person<sup>1</sup>)

8A. Name

8B. Surname

8C. Phone Number (Optional Field)

Residential Address.

8D. Street

8E. House/Apartment Number

8F. Postal Code and City

8G. Name

8H. Surname

8I. Phone Number (Optional Field)

8J. Street

8K. House/Apartment Number

8L. Postal Code and Cit

## II. PROVIDER INFORMATION

9. Pursuant to Article 9(1) of the Act of October 27, 2017, on primary health care (Journal of Laws of 2020, item 172), I declare my choice:

9A. Name (Company) of the Provider

9B. Address of the Provider's Headquarters

10. In the current calendar year, I am making the choice<sup>2</sup>:

*(The leftmost field)* For the first time or for the second time

*(The next field to the right)* For the third time and subsequent<sup>3</sup>

11. If you are making the choice for the third time or more in the current calendar year, please indicate whether the reason for making the choice is: *(listed in order)*

o The circumstance specified in Article 9(5) of the Act of October 27, 2017, on primary health care:

- Change of place of residence
- Termination of the provision of healthcare services by the selected provider, primary healthcare physician at the selected provider.
- The recipient reaching the age of 18, when the primary healthcare physician is a doctor with a specialization of the first or second degree or the title of specialist in the field of pediatrics
- For other reasons arising on the part of the provider (please specify).

.....  
*(Space to write down the reasons for changing the declaration once again)*

o Another circumstance

## III. INFORMATION REGARDING THE PRIMARY HEALTHCARE PHYSICIAN

12. Pursuant to Article 9(2) of the Act of October 27, 2017, on primary health care, I declare my choice:<sup>4</sup>)

First and Last Name of the Primary Healthcare Physician

*(Please provide the Name and Last Name of Your Healthcare Physician)*

13. In the current calendar year, I am making the choice<sup>2</sup>:

*(The leftmost field)* For the first time or for the second time

*(The next field to the right)* For the third time and subsequent<sup>3</sup>

14. If you are making the choice for the third time or more in the current calendar year, please indicate whether the reason for making the choice is:

o The circumstance specified in Article 9(5) of the Act of October 27, 2017, on primary health care:

- Change of place of residence
- Termination of the provision of healthcare services by the selected provider, primary healthcare physician at the selected provider.
- The recipient reaching the age of 18, when the primary healthcare physician is a doctor with a specialization of the first or second degree or the title of specialist in the field of pediatrics
- For other reasons arising on the part of the provider (please specify).

.....  
*(Space to write down the reasons for changing the declaration once again)*

o Another circumstance

*(The leftmost field)* Date

*(The next field to the right)* Signature of the Recipient or Legal Representative<sup>5</sup>

## EXPLANATIONS:

- <sup>1</sup> Declarations made by legal representatives on behalf of minors, after they reach legal adulthood, remain valid until the selection of another primary healthcare physician. In cases where the primary healthcare physician holds a specialization of the first or second degree or the title of specialist in the field of pediatrics, the declarations remain valid for the choice of the healthcare provider until the selection of another primary healthcare physician or a new healthcare provider (Article 6(3) and Article 10(7) of the Act of October 27, 2017, on primary health care).
- <sup>2</sup> The recipient has the right to choose a healthcare provider or primary healthcare physician free of charge no more than twice in a calendar year. In the case of each subsequent change, a fee of PLN 80 is charged. The recipient is not required to pay a fee in the event of a change of their place of residence, the cessation of healthcare services by the selected provider, primary healthcare physician at the selected provider, or when the recipient, whose primary healthcare physician is a doctor with a specialization of the first or second degree or the title of specialist in the field of pediatrics, reaches the age of 18, or for other reasons arising on the part of the provider (Article 9(4) and (5) of the Act of October 27, 2017, on primary health care)
- <sup>3</sup> In the case of the third and subsequent choices, it is necessary to indicate whether the reason for making the choice is the circumstance specified in Article 9(5) of the Act of October 27, 2017, on primary health care, namely, a change in the place of residence of the recipient or the cessation of healthcare services by the selected provider, primary healthcare physician at the selected provider, or a change of the primary healthcare physician, when the recipient, whose primary healthcare physician is a doctor with a specialization of the first or second degree or the title of specialist in the field of pediatrics, has reached the age of 18, or for other reasons arising on the part of the provider.
- <sup>4</sup> The recipient may choose a primary healthcare physician, a primary healthcare nurse, or a primary healthcare midwife at the same provider, at different providers, or who are providers (Article 9(3) of the Act of October 27, 2017, on primary health care).
- <sup>5</sup> This is completed in the case of declarations submitted in paper or electronic form, as specified in Article 10(1)(1) or (2) of the Act of October 27, 2017, on primary health care.

**PART 2. DECLARATION OF CHOICE OF A HEALTHCARE PROVIDER PROVIDING PRIMARY HEALTHCARE SERVICES, INCLUDING A PRIMARY HEALTHCARE NURSE**

**I. PATIENT INFORMATION**

1. Name
2. Surname
3. Date of Birth
4. Personal Identification Number, In the absence thereof, provide the series and number of the identity confirming document
5. Residential Address.
  - 5A. Street
  - 5B. House/Apartment Number
  - 5C. Postal Code and City
6. Phone Number (Optional Field)
7. Email Address (Optional Field)
8. Information Regarding the Legal Representative (in case the recipient of services is a minor or legally incapacitated person<sup>1</sup>)
  - 8A. Name
  - 8B. Surname
  - 8C. Phone Number (Optional Field)
  - Residential Address.
    - 8D. Street
    - 8E. House/Apartment Number
    - 8F. Postal Code and City
  - 8G. Name
  - 8H. Surname
  - 8I. Phone Number (Optional Field)
  - 8J. Street
  - 8K. House/Apartment Number
  - 8L. Postal Code and Cit

**II. PROVIDER INFORMATION**

9. Pursuant to Article 9(1) of the Act of October 27, 2017, on primary health care (Journal of Laws of 2020, item 172), I declare my choice:
  - 9A. Name (Company) of the Provider
  - 9B. Address of the Provider's Headquarters
10. In the current calendar year, I am making the choice<sup>2</sup>:
  - (*The leftmost field*) For the first time or for the second time
  - (*The next field to the right*) For the third time and subsequent<sup>3</sup>

11. If you are making the choice for the third time or more in the current calendar year, please indicate whether the reason for making the choice is: *(listed in order)*
- o The circumstance specified in Article 9(5) of the Act of October 27, 2017, on primary health care:
    - Change of place of residence
    - Termination of the provision of healthcare services by the selected provider, primary healthcare physician at the selected provider.
    - The recipient reaching the age of 18, when the primary healthcare physician is a doctor with a specialization of the first or second degree or the title of specialist in the field of pediatrics
    - For other reasons arising on the part of the provider (please specify).

.....  
*(Space to write down the reasons for changing the declaration once again)*

- o Another circumstance

**III. INFORMATION REGARDING THE PRIMARY HEALTHCARE NURSE**

12. Pursuant to Article 9(2) of the Act of October 27, 2017, on primary health care, I declare my choice<sup>4</sup>

*First and Last Name of the Primary Healthcare Nurse*

*(Please provide the Name and Last Name of Your Primary Healthcare Nurse)*

13. In the current calendar year, I am making the choice<sup>2</sup>:

*(The leftmost field)* For the first time or for the second time

*(The next field to the right)* For the third time and subsequent<sup>3</sup>

14. If you are making the choice for the third time or more in the current calendar year, please indicate whether the reason for making the choice is:

- o The circumstance specified in Article 9(5) of the Act of October 27, 2017, on primary health care:
  - Change of place of residence
  - Termination of the provision of healthcare services by the selected provider, primary healthcare physician at the selected provider.
  - The recipient reaching the age of 18, when the primary healthcare physician is a doctor with a specialization of the first or second degree or the title of specialist in the field of pediatrics
  - For other reasons arising on the part of the provider (please specify).

.....  
*(Space to write down the reasons for changing the declaration once again)*

- o Another circumstance

*(The leftmost field)* Date

*(The next field to the right)* Signature of the Recipient or Legal Representative<sup>5</sup>

## EXPLANATIONS:

- <sup>1</sup> Declarations made by legal representatives on behalf of minors, after they reach legal adulthood, remain valid until the selection of another primary healthcare physician. In cases where the primary healthcare physician holds a specialization of the first or second degree or the title of specialist in the field of pediatrics, the declarations remain valid for the choice of the healthcare provider until the selection of another primary healthcare physician or a new healthcare provider (Article 6(3) and Article 10(7) of the Act of October 27, 2017, on primary health care).
- <sup>2</sup> The recipient has the right to choose a healthcare provider or primary healthcare physician free of charge no more than twice in a calendar year. In the case of each subsequent change, a fee of PLN 80 is charged. The recipient is not required to pay a fee in the event of a change of their place of residence, the cessation of healthcare services by the selected provider, primary healthcare physician at the selected provider, or when the recipient, whose primary healthcare physician is a doctor with a specialization of the first or second degree or the title of specialist in the field of pediatrics, reaches the age of 18, or for other reasons arising on the part of the provider (Article 9(4) and (5) of the Act of October 27, 2017, on primary health care)
- <sup>3</sup> In the case of the third and subsequent choices, it is necessary to indicate whether the reason for making the choice is the circumstance specified in Article 9(5) of the Act of October 27, 2017, on primary health care, namely, a change in the place of residence of the recipient or the cessation of healthcare services by the selected provider, primary healthcare physician at the selected provider, or a change of the primary healthcare physician, when the recipient, whose primary healthcare physician is a doctor with a specialization of the first or second degree or the title of specialist in the field of pediatrics, has reached the age of 18, or for other reasons arising on the part of the provider.
- <sup>4</sup> The recipient may choose a primary healthcare physician, a primary healthcare nurse, or a primary healthcare midwife at the same provider, at different providers, or who are providers (Article 9(3) of the Act of October 27, 2017, on primary health care).
- <sup>5</sup> This is completed in the case of declarations submitted in paper or electronic form, as specified in Article 10(1)(1) or (2) of the Act of October 27, 2017, on primary health care.

**PART 3. DECLARATION OF CHOICE OF A HEALTHCARE PROVIDER PROVIDING PRIMARY HEALTHCARE SERVICES, INCLUDING A PRIMARY HEALTHCARE MIDWIFE**

**I. PATIENT INFORMATION**

1. Name
2. Surname
3. Date of Birth
4. Personal Identification Number, In the absence thereof, provide the series and number of the identity confirming document
5. Residential Address.
  - 5A. Street
  - 5B. House/Apartment Number
  - 5C. Postal Code and City
6. Phone Number (Optional Field)
7. Email Address (Optional Field)
8. Information Regarding the Legal Representative (in case the recipient of services is a minor or legally incapacitated person<sup>1</sup>)
  - 8A. Name
  - 8B. Surname
  - 8C. Phone Number (Optional Field)
  - Residential Address.
    - 8D. Street
    - 8E. House/Apartment Number
    - 8F. Postal Code and City
  - 8G. Name
  - 8H. Surname
  - 8I. Phone Number (Optional Field)
  - 8J. Street
  - 8K. House/Apartment Number
  - 8L. Postal Code and Cit

**II. PROVIDER INFORMATION**

9. Pursuant to Article 9(1) of the Act of October 27, 2017, on primary health care (Journal of Laws of 2020, item 172), I declare my choice:
  - 9A. Name (Company) of the Provider
  - 9B. Address of the Provider's Headquarters
10. In the current calendar year, I am making the choice<sup>2</sup>:
  - (*The leftmost field*) For the first time or for the second time
  - (*The next field to the right*) For the third time and subsequent<sup>3</sup>



11. If you are making the choice for the third time or more in the current calendar year, please indicate whether the reason for making the choice is: *(listed in order)*
- o The circumstance specified in Article 9(5) of the Act of October 27, 2017, on primary health care:
    - Change of place of residence
    - Termination of the provision of healthcare services by the selected provider, primary healthcare physician at the selected provider.
    - The recipient reaching the age of 18, when the primary healthcare physician is a doctor with a specialization of the first or second degree or the title of specialist in the field of pediatrics
    - For other reasons arising on the part of the provider (please specify).

.....  
*(Space to write down the reasons for changing the declaration once again)*

- o Another circumstance

**III. INFORMATION REGARDING THE PRIMARY HEALTHCARE MIDWIFE**

12. Pursuant to Article 9(2) of the Act of October 27, 2017, on primary health care, I declare my choice<sup>4</sup>

*First and Last Name of the Primary Healthcare Nurse*

*(Please provide the Name and Last Name of Your Primary Healthcare Nurse)*

13. In the current calendar year, I am making the choice<sup>2</sup>:

*(The leftmost field)* For the first time or for the second time

*(The next field to the right)* For the third time and subsequent<sup>3</sup>

14. If you are making the choice for the third time or more in the current calendar year, please indicate whether the reason for making the choice is:

- o The circumstance specified in Article 9(5) of the Act of October 27, 2017, on primary health care:
  - Change of place of residence
  - Termination of the provision of healthcare services by the selected provider, primary healthcare physician at the selected provider.
  - The recipient reaching the age of 18, when the primary healthcare physician is a doctor with a specialization of the first or second degree or the title of specialist in the field of pediatrics
  - For other reasons arising on the part of the provider (please specify).

.....  
*(Space to write down the reasons for changing the declaration once again)*

- o Another circumstance

*(The leftmost field)* Date

*(The next field to the right)* Signature of the Recipient or Legal Representative<sup>5</sup>

## EXPLANATIONS:

- <sup>1</sup> Declarations made by legal representatives on behalf of minors, after they reach legal adulthood, remain valid until the selection of another primary healthcare physician. In cases where the primary healthcare physician holds a specialization of the first or second degree or the title of specialist in the field of pediatrics, the declarations remain valid for the choice of the healthcare provider until the selection of another primary healthcare physician or a new healthcare provider (Article 6(3) and Article 10(7) of the Act of October 27, 2017, on primary health care).
- <sup>2</sup> The recipient has the right to choose a healthcare provider or primary healthcare physician free of charge no more than twice in a calendar year. In the case of each subsequent change, a fee of PLN 80 is charged. The recipient is not required to pay a fee in the event of a change of their place of residence, the cessation of healthcare services by the selected provider, primary healthcare physician at the selected provider, or when the recipient, whose primary healthcare physician is a doctor with a specialization of the first or second degree or the title of specialist in the field of pediatrics, reaches the age of 18, or for other reasons arising on the part of the provider (Article 9(4) and (5) of the Act of October 27, 2017, on primary health care)
- <sup>3</sup> In the case of the third and subsequent choices, it is necessary to indicate whether the reason for making the choice is the circumstance specified in Article 9(5) of the Act of October 27, 2017, on primary health care, namely, a change in the place of residence of the recipient or the cessation of healthcare services by the selected provider, primary healthcare physician at the selected provider, or a change of the primary healthcare physician, when the recipient, whose primary healthcare physician is a doctor with a specialization of the first or second degree or the title of specialist in the field of pediatrics, has reached the age of 18, or for other reasons arising on the part of the provider.
- <sup>4</sup> The recipient may choose a primary healthcare physician, a primary healthcare nurse, or a primary healthcare midwife at the same provider, at different providers, or who are providers (Article 9(3) of the Act of October 27, 2017, on primary health care).
- <sup>5</sup> This is completed in the case of declarations submitted in paper or electronic form, as specified in Article 10(1)(1) or (2) of the Act of October 27, 2017, on primary health care.