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| LOGO-OKANA-2.jpg APPLICATION FORM  ORGANIZATION AGAINST DRUGS (O.KA.NA.), GREECE | | | | | | |
| SEX | MALE  € | FEMALE  € | | OTHER  € |  | |
|  | | | | | | |
| PERSONAL INFORMATION | SURNAME (FAMILY NAME) | NAME  (GIVEN NAME) | | FATHER’S NAME | DATE OF BIRTH | PASSPORT NUMBER/  ID |
|  |  |  | |  |  |  |
|  | | | | | | |
| CONTACT INFORMATION | RESIDENTIAL ADDRESS (hometown) | | RESIDENTIAL ADDRESS  (In Greece) | TELEPHONE NUMBER (In Greece) | email: | |
|  |  | |  |  |  | |
|  | | | | | | |
| APPLYING  FOR | METHADONE  € | BUPRENORPHINE  € | |  | | |
|  | PERIOD OF TIME (dates) | FROM: | | TO: |  | |
| REASON FOR APPLYING | LIVING IN GREECE € | WORKING IN GREECE: € | |  | | |
|  | | | | | | |
| MAINTANENCE PROGRAM INFORMATION  (hometown) | NAME OF THE CLINIC | | | * Telephone number: * Email: | | |
|  | NAME OF THE DOCTOR: | | | | | |
|  | DAILY DOSAGE (mg): | | | | | |
|  | | | | | | |
| DECLARATION/  PRIVACY  STATEMENT | I confirm that the information I have provided in this application is complete to the best of my knowledge. The collection, use and disclosure of the information provided are in accordance with GDPR Regulation. The information collected may be disclosed to health practitioners when necessary to facilitate coordination of treatment and patient safety. | | | | | |
|  | | | | Date: | Signature: | |
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