**TERMO DE RESPONSABILIDADE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, portador (a) do CPF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (profissão) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, registrado no Conselho de Classe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, proprietário (a) / responsável pelo Estabelecimento de Saúde \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, registrado no CNPJ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, CNES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, **DECLARO** para fins de **VACINAÇÃO COVID-19**, que os trabalhadores abaixo relacionados, estão devidamente vinculados, de forma ativa, ao estabelecimento de saúde informado. Declaro estar ciente das penalidades sujeitas caso as informações prestadas sejam inverídicas.

Nome do Trabalhador Função Conselho de Classe

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Capinzal – SC, \_\_\_\_\_ de \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ de 2021

proprietário (a) / responsável

CPF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_