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| **DEPENDENCIA:** | **ASUNTO:** |
| **FECHA:** | **LUGAR:** |

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| Nombres y apellidos | Documento | Edad | Hora | Consulta médica en Centro Día | | Asesoría Psicosocial | | Nombre Taller y/o Capacitación | Alimentación | | | Firma |
| Si | No | Si | No | Desayuno | Almuerzo | Refrigerio |
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