楚雄州人民医院 技术临床应用规范化培训

基地培训报名表

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 姓名 |  | | | | 性别 | | | | | |  | | | | 年龄 | | | | | | |  | | | | | | | | | | 照片  （加盖医院公章） |
| 身份证号码 | |  |  |  | | |  |  | |  | |  | |  | |  |  |  | | |  | |  | |  |  |  | |  |  | |
| 工作单位  名称 | |  | | | | 工作单位  级别 | | | | | | |  | | | | | | | 参加工作  时间 | | | | | | | |  | | | |
| 专 业 | |  | | | | 最高学历/学 位 | | | | | | |  | | | | | | | 最高职称 | | | | | | | |  | | | |
| 工作科室名称 | |  | | | | | | | | | | | 所在科室是否开展该技术 | | | | | | | | | | |  | | | | | | | | |
| 医师资格  证书编码 | |  | | | | | | | | | | | 医师执业  证书编码 | | | | | | | | | | |  | | | | | | | | |
| 单位通讯地址  邮编 | | |  | | | | | | | | | | | | | | | | 个人联系  方式 | | | | | | | | | 手机： | | | | |
| 单位联系电话 | | |  | | | | | | | | | | | | | | | | 邮箱： | | | | |
| 主要  工作  经历 | | 时 间 | | | | | | | 工 作 单 位 | | | | | | | | | | | | | | | | | | | | | | 职称/职务 | |
|  | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | |
| 申报  单位  意见 | | （盖章）  　　　　　 年 　 月 　 日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 培训  单位  审批  意见 | | （盖章）  　　　　　 年 　 月 　 日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

注：请认真、完整、准确地填写相关信息，并打印、加盖医院公章后方有效。