附件2

凉山彝族自治州第一人民医院单位委培住院医师规范化培训报名汇总表

医院（公章）： 单位联系人： 联系电话 ： 电子邮箱： 填表日期：

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| **序号** | **培训专业****名称** | **姓名** | **性****别** | **现从事****专业** | **身份证号码** | **毕业院校** | **学历** | **所学专业** | **毕业时间****（年月）** | **是否有医师资格证** |
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| **合计** |  |  |  |  |  |  |  |  |  |  |

备注：我院8个国家住院医师规范化培训基地专业请参阅招生简章所列专业。