**附件：**

单位委培住院医师报名汇总表

医院（公章）： 单位联系人： 联系电话 ： 电子邮箱： 填表日期：

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**  **执业证** |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |