附件：

贴两寸彩照

**成都市妇女儿童中心医院**

**住院医师规范化培训报名表（2024）**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓名 | |  | | | 出生日期 | | | |  | | | | 政治面貌 | | | | |  |
| 性别 | |  | | | 籍贯 | | | |  | | | | 民族 | | | | |  |
| 有无医师执照 | |  | | | 资格证编号 | | | |  | | | | 执业证编号 | | | | |  |
| 所学专业 | |  | | | 最高学历 | | | |  | | | | 是否全日制 | | | | |  |
| 毕业时间 | |  | | | 是否单位委培 | | | |  | | | | 委培原单位 | | | | |  |
| 毕业学校 | |  | | | | | | | 身份证号 | | | |  | | | | | |
| 培训专业志愿第一： 第二： | | | | | | | | | | | | | | | | | | |
| 家庭住址：家庭电话： | | | | | | | | | | | | | | | | | | |
| 本人联系方式 | | 手机 | |  | | | | | | | | 电话 | | | | |  | |
| E-mail | |  | | | | | | | | 其它方式 | | | | |  | |
| 临床工作经历 | | | | | | | | | | | | | | | | | | |
| 临床工作起止时间 | 时间长度 | 医院  名称 | 医院级别 | | | 科室 | | 职务 | | | 证明人 | | | | 证明人  现任何职 | | | 证明人  联系电话 |
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| 参加住院医师培训最大的几点愿望 | |  | | | | | | | | | | | | | | | | |
| 参加住院医师培训最大的几点顾虑 | |  | | | | | | | | | | | | | | | | |
| 履历（包括高中以上学历） | | | | | | | | | | | | | | | | | | |
| 年月日至  年月日 | | 何单位 | | | | | 任何职 | | | | | | | 离开方式 | | | | |
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| 成都地区  联络人员 | | 姓名 | | | 关系 | | | | | 工作单位 | | | | | | 联络方法 | | |
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| 信息确认 | | 本人承诺：以上填报信息均为真实信息。如有作假，后果自负。  承诺人： （手写正楷签名）  日期： | | | | | | | | | | | | | | | | |