**附件**

**江苏省中西医结合医院**

**“单位委托培养”住院医师规范化培训学员报名登记表**

报名序号：

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| **基 本 情 况** | 姓 名 |  | | | | | | | 性别 | | | |  | | | | 出生年月 | | | | |  | | | | | | | （贴照片处） | |
| 政治面貌 |  | | | | | | | 民族 | | | |  | | | | 健康状况 | | | | |  | | | | | | |
| 身份证号 |  |  | |  |  | |  | |  |  |  | |  | |  | |  |  |  |  | |  | |  | |  |  | |  | |
| 外语水平 |  | | | | | | | 所在单位 | | | | | | | |  | | | | | | | | | | | |  | |
| 通讯地址 |  | | | | | | | | | | | | | | | | | | | | | | 邮政编码 | | | | |  | |
| 电子邮箱 |  | | | | | | | 联系电话 | | | | | |  | | | | | | | | | 手 机 | | | | |  | |
| 14天内是否有中高风险（含境外）地区旅居史 |  | | | | | | | 苏康码/行程码颜色 | | | | | |  | | | | | | | | | 是否接种新冠病毒疫苗 | | | | |  | |
| **报名情况** | 培训类别 | | | □ 中医 □ 中医全科 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 培训学科（如选“中医”类别需勾选一项） | | | □ 中医内科，□ 中医外科，□ 中医妇科，□ 中医儿科，□ 中医骨伤科，□ 针灸科、推拿科、中医康复科，□ 中医耳鼻喉，□ 中医眼科 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 培训时间 | | | □ 3年（ 本科、学术型研究生） □ 2年（专业型硕士） □ 1年（专业型博士） □其他 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **教育情况(从第一学历填起)** | 入学日期 | 毕业日期 | | | | | 学校名称 | | | | | | | | | | 专 业 | | | | | | | | | 学 历 | | | 学 位 | |
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| **所经历的社会工作、任职及获奖情况** | 时 间 | | | 社会工作及任职情况 | | | | | | | | | | | | | | | | | | 获奖情况 | | | | | | | | |
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| **承诺** | **我承诺以上信息真实可靠。**  签字： 日期： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **单位** | **该学员已招聘为本单位 岗位医师，现本单位同意委派该住院医师全程在江苏省中西医结合医院接受住院医师规范化培训，并承诺不会因单位工作等原因将该医师调回，且在培训期间将积极配合培训基地的各项管理。**  单位(盖章)： 法人(签章)： 日期： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |