**江苏省肿瘤医院**

**附件：**

**住院医师规范化培训学员报名申请表**

**报名序号：**

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| 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 | |  | |  | |  | |  | |  | | | |  | |  |  | |  | |  | | |  | |  |  |  | |  | | |  |  |  | |
| 电子邮箱 | |  | | | | | | | | | | | | | | | 联系电话 | | | | | | | |  | | | | | | | | | | | 英 语  水 平 | | |  |
| 手机号码 | |  |  | |  | |  | |  | | |  | | |  | |  |  | |  | | |  | | 最 高  学 历 | | | | |  | | | | | | 最 高  学 位 | | |  |
| **申请培训专业** | | □放射肿瘤科 □外科—胸心外科方向 □麻醉科 □放射科  □超声医学科 □临床病理科 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **高**  **等**  **教**  **育**  **经**  **历** | | 起止年月 | | | | | | | | | | | 毕业院校 | | | | | | | | | | | | | 专业 | | | | | 学历 | | | | | | | 学位 | |
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| **工**  **作**  **经**  **历** | | 起止年月 | | | | | | | | | | | 工作单位 | | | | | | | | | | | | | 科室 | | | | | 获奖与社会工作 | | | | | | | | |
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| 是否取得执业医师资格 | | | | | | | | | | | | | | | | | | | | | | | | | | □是 □否 | | | | | | | | | | | | | |
| 本人承诺以上信息真实可靠。 签字： 日期： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **委**  **培**  **学**  **员**  **填**  **写** | 选送单位 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | 医院等级 | | | | | |  | |
| 单位地址 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | 单位联系人 | | | | | |  | |
| 联系人电话 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | 是否递交委培公函 | | | | | |  | |
| 单位意见： 盖章： 日期： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |