**附件4： 连云港市第二人民医院住院医师规范化培训**

**社会化报名表**

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  （既往病史） | | | | |  | | | |
| 身份证号 |  | |  | |  |  |  | |  | |  | |  |  | |  | |  |  | |  |  |  | |  |  |  |
| 外语水平 |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 最高学历 |  | | | | | | | | | 毕业证书编号 | | | | | | |  | | | | | | | | | | | | |
| 最高学位 |  | | | | | | | | | 学位证书编号 | | | | | | |  | | | | | | | | | | | | |
| 学位类型（硕、博） | □科学型 □专业型 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 通讯地址 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 电子邮箱 |  | | | | | | | | | 住宅电话 | | | | | | |  | | | | | | | 手机 | | | |  | |
| **报 名 情 况** | 报考培训专业 | | | | 1、 | | | | | | | | 2、 | | | | | | | | 是否服从调剂 | | | | |  | | 执业范围 | |  |
| 医师资格证书取得时间 | | | | | | | |  | | | | | | | | | 医师资格证书编号 | | | | | | |  | | | | | |
| 医师执业证书取得时间 | | | | | | | |  | | | | | | | | | 医师执业证书编号 | | | | | | |  | | | | | |
| **教 育 情 况** | 入学日期 | | 毕业日期 | | | | | | 学校名称 | | | | | | | | | 专业 | | | | | | | 学历 | | | | 学位 | |
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| **工 作 情 况** | 工作时间 | | | | | | | | 单位名称 | | | | | | | | | 单位级别 | | | | | | | 从事岗位 | | | | | |
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| **个 人 承 诺** | **1、本人承诺以上信息真实可靠。**  **2、本人自愿在连云港市第二人民医院接受住院医师规范化培训。**  本人签字：年 月 日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

连云港市第二人民医院 科教部住培办