**2019年社区卫生服务中心招聘**

**医疗专业技术人员登记表**

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| 姓 名 |  | | | | 性 别 |  | | 民 族 | | |  | | | 照片 |
| 出 生  年 月 |  | | | | 籍 贯 |  | | 政治面貌 | | |  | | |
| 全日制教育学历及  毕业院校 | | | | |  | | | | | | | | |
| 在职教育（最高）学历及毕业院校 | | | | |  | | | | | | | | |
| 职称 |  | | | | 身份证号码 | |  | | | | | | | |
| 取得执业资格证书时间 | | |  | | | 执业类别 | | |  | | | | | |
| 执业专业 | | |  | | | 是否取得规范化培训结业证书 | | | | | | |  | |
| 是否取得全科医学专业医师资格 | | | | | |  | | | | | | | | |
| 联系电话 | |  | | | | | | | | | | | | |
| 拟报中心 | |  | | | | 是否服从调剂 | | | |  | | | | |
| 个 人 简 历 | | | | | | | | | | | | | | |
| 起止年月 | | | | 学习（工作）单位 | | | | | | | | 备注 | | |
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| 人事科审查意见  （签字、盖章）  年 月 日 |
| 医政科审查意见  （签字、盖章）  年 月 日 |
| 市卫生健康委意见  （签字、盖章）  年 月 日 |