附件2

2019年特岗全科医生基本信息登记表

服务单位：  市 县（市、区）

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1.个人基本信息** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 姓 名 | | |  | | | | | | 性 别 | | |  | | | | | | | | | 相  片 | | | | | |
| 出生年月 | | |  | | | | | | 民 族 | | |  | | | | | | | | |
| 籍 贯 | | |  | | | | | | 政治面貌 | | |  | | | | | | | | |
| 学 历 | | |  | | | | | | 学 位 | | |  | | | | | | | | |
| 专业技术资格 | | |  | | | | | | 婚姻状况 | | |  | | | | | | | | |
| 身份证号 | | |  | | | | | | | | | | | | | | | | | |
| 家庭详细地址 | | |  | | | | | | | | | | | 户籍所在地 | | | | | | |  | | | | | |
| 联系电话 | | |  | | | | | 电子邮箱 | | | | | |  | | | | | | | | | | | | |
| 邮政编码 | | |  | | | | | 档案保管单位 | | | | | |  | | | | | | | | | | | | |
| **2.执业医师资格相关信息** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医师资格证书编码 | | | | |  | | | | | | | | | | | 发证时间 | | | | | |  | | | | |
| 执业类别及范围 | | | | | □临床类别全科医学专业 □临床类别内科专业  □中医类别全科医学专业 □中医类别中医专业  □其他：请注明: | | | | | | | | | | | | | | | | | | | | | |
| 受聘前是否注册执业 | | | | | □是 □否 | | | | | | | | | | | | | | | | | | | | | |
| 医师执业证书编码 | | | | |  | | | | | | | | 发证时间 | | | | | | |  | | | | | | |
| 执业地点 | | | | |  | | | | | | | | 执业范围 | | | | | | |  | | | | | | |
| **3.教育培训情况(从中专填起,含进修和培训)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 起始年月 | | 终止年月 | | | | | 学校名称 | | | | | | | | 专业 | | | | | | | | | 学历学位 | | |
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|  | |  | | | | |  | | | | | | | |  | | | | | | | | |  | | |
| **4.是否参加过省级卫生行政部门（含中医药管理部门）组织的全科医生规范化培养、转岗培训或者岗位培训** | | | | | | | | | | | | | | | | | | | | | | | | □是  □否 | | |
| 考核是否合格 | | | | | | | | | | □是 □否 | | | | | | | | | | | | | | | | |
| **5.工作经历** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 起始年月 | 终止年月 | | | | | 工作单位 | | | | | | | | | | | | | 职称 | | | | | 从事专业 | | |
|  |  | | | | |  | | | | | | | | | | | | |  | | | | |  | | |
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| **6.特岗全科医生服务单位基本信息** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 设岗县级公立医疗机构 | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| 通讯地址 | | | | | | | | |  | | | | | | | | 邮政编码 | | | | | | | |  | |
| 联系电话 | | | | | | | | |  | | | | | | | | 传真电话 | | | | | | | |  | |
| 派驻乡镇卫生院 | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| 通讯地址 | | | | | | | | |  | | | | | | | | | 邮政编码 | | | | | | | |  |
| 联系电话 | | | | | | | | |  | | | | | | | | | 传真电话 | | | | | | | |  |
| **7.受聘后执业注册情况** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医师执业证书编码 | | | |  | | | | | | | 变更或注册时间 | | | | | | | | | | | |  | | | |
| 执业地点 | | | |  | | | | | | | 执业范围 | | | | | | | | | | | |  | | | |

备注：此表一式五份，自治区、市、县级卫生健康（计生）行政部门和设岗县级公立医疗机构、派驻乡镇卫生院各存一份。