附件1

传统医学师承关系人员资格审核表

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| 指 导 老 师 | 姓 名 |  | | | | 性别 | |  | | | | 民 族 | | | | |  | 照片 |
| 籍 贯 |  | | | | 出生  年月 | |  | | | | 年 龄 | | | | |  |
| 卫生专业技术职务 | | | | |  | | | | | | | | | | | |
| 何时  受聘 |  | | | | 在职或返聘 | | | | | | |  | | | | |
| 现执业机构 | | | | |  | | | | | | | | | 身 体  状 况 | | |  |
| 学科  专业 |  | | | | 何时从事  本专业工作 | | | | |  | | | | 联 系  电 话 | | |  |
| 身份证号码 | | | | |  | | | | | | | | | | | | |
| 医师资格证书编码 | | | | |  | | | | | | | | | | | | |
| 医师执业证书编码 | | | | |  | | | | | | | | | | | | |
| 执业级别 | | |  | | | | | | | 执业类别 | | | | | | |  |
| 医师执业证书首次获得时间 | | | | | | | | 年 月 日 | | | | | | | | | |
| 通讯  地址 |  | | | | | | | | | | | | | 邮 编 | | |  |
| 是否能在带教医疗机构坚持每周不少于2天的带教 | | | | | | | | | | | | | | | | |  |
| 主要学术思想、临床经验和学术专长 | 签名： 年 月 日 | | | | | | | | | | | | | | | | |
| 师承人员 | 姓 名 |  | | | | 性 别 | |  | | | | 年 龄 | | | |  | | 照片 |
| 出生  年月 |  | | | | 籍 贯 | |  | | | | 民 族 | | | |  | |
| 出生  地点 |  | | | | 学 历 | |  | | | | 学 位 | | | |  | |
| 单位名称 | |  | | | | | | | | | | | | | | |
| 家庭地址 | | | |  | | | | | | | | | | | | | |
| 户籍所在地 | | | |  | | | | | | | | | | | | | |
| 通讯地址及邮政编码 | | | |  | | | | | | | | | | | | | |
| 跟师学习机构及地址 | | | |  | | | | | | | | | | | | | |
| 参加工作时间 |  | | | | | 现从事主要职业 | | | | | | | | | |  | |
| 身份证  号码 |  | | | | | | | | 联系电话  手机 | | | | | | |  | |
| 个 人 简 历 | | | | | | | | | | | | | | | | | |
| 起止  年月 | 学习（工作）单位 | | | | | | | | | | | | 毕（结）业 | | | | |
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| 指导老师执业地点（带教单位）意见：  （盖章）  年 月 日 | | | | | | | | | | | | | | | | | | |
| 核准指导老师执业的卫生行政部门初审意见：  （盖章）  年 月 日 | | | | | | | | | | | | | | | | | | |
| 市地卫生行政部门审核意见：  （盖章）  年 月 日 | | | | | | | | | | | | | | | | | | |

附件2

传统医学师承人员申请跟师学习备案汇总表

市（地）卫生健康委（加盖公章）

|  |  |  |  |  |  |  |  |  |  |  |
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| 序号 | 姓 名 | 性别 | 身份证号码 | 学习专业 | 联系电话 | 实践机构 | 指导老师 | 专业 | 身份证号码 | 公证时间 |
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