附件

山西省住院医师规范化培训年限减免申请表  **培训基地： 年 月 日**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **姓名** |  | | **网报号** | |  | | **性别** | | |  | **手机** |  | |
| **身份证号** | |  | | | | | **邮箱** | | |  | | | |
| **减免类型** | |  | | **减免年限** | | |  | | | **培训专业** | |  | |
| **学历信息（研究生填写）** | | | | | | | | | | | | | |
| **学历** | **毕业院校** | | | | **专业** | | | **导师姓名** | | **毕业证书编号** | | | |
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| **临床经历** | | | | | | | | | | | | | |
| **轮转科室** | | | | | | **起止时间（年月）** | | | | | **合计（月）** | | **证明人** |
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| 所在培养或委派单位：  （盖章） | | | | | | | | | 培训基地意见： 负责人：  （盖章） | | | | |