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） | | | | |