**附件5**

**××××年北京市住院医师规范化培训结业临床实践能力考核报名资格审核表**

**单位：（加盖单位公章） 联系人： 　 　　　　　联系电话：**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **序号** | **姓名** | **培训专业** | **医师编号** | **最高**  **学历** | **国家医师资格证书** | **培训年限** | **进入基地时间** | **完成培训时间** | **市卫计委终审**  **结果** |
| 1 |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |  |  |