附件3

2025—2026年度全科医生转岗培训报名汇总表

县（市、区）卫生健康局/医疗机构（盖章） 填表人： 填表时间： 年 月 日 联系方式：

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| **序号** | **县（市、区）** | **姓名** | **性别** | **出生年月** | **职称** | **学历** | **现从事专业** | **所在单位** | **单位类别** | **医师资格证书编码** | **医师执业证书编码** | **具有的相关培训内容减免情形及减免办法** | **联系电话** | **备注** |
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**注：1.出生年月栏样式例：198901；2.单位类别填二级以上医院、乡镇卫生院、社区卫生服务中心等**