附件1

参培人员回执

单位名称：

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| --- | --- | --- | --- | --- | --- | --- | --- |
| 联系人 | |  | | | 电 话 |  | |
| 发票抬头 | |  | | | 邮 箱 |  | |
| 纳税人识别号 | |  | | | | | |
| 参训人员信息 | | | | | | | |
| 姓名 | 性别 | | 科室及职务 | 联系电话 | | | 参培项目（临床或护理) |
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备注：请务必填写临床或是护理，以便入群审核参加培训。