附件1:

成都市第一人民医院专科护士培训申请表

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **姓名** |  | | | **性别** |  | **年龄** | |  | | **民族** |  | | **贴照片处** |
| **籍贯** |  | | | | | **政治面貌** | | | | |  | |
| **文化程度** | |  | | | | **职称/职务** | | | | |  | |
| **工作单位** | |  | | | | | | | | | | |
| **单位地址** | |  | | | | | | | | | | |
| **单位电话** | |  | | | | | **手机号码** | |  | | | **微信号** |  |
| **申请培训专业** | | |  | | | | **培训时间** | |  | | | **电子邮箱** |  |
| **护士执业证编号** | | |  | | | | | | **最近注册时间** | | |  | |
| **身份证号码** | | |  | | | | | | | | | | |
| **主要工作经历** | | |  | | | | | | | | | | |
| **选送单位意见** | | | **（盖章）**  **年　　月　　日** | | | | | | | | | | |
| **接受单位意见** | | | **（盖章）**  **年　　月　　日** | | | | | | | | | | |
| **备注** | | |  | | | | | | | | | | |