**2018年专业技术职务聘任材料审查表**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 科室 | |  | | | | | | 拟申报专业及  任职资格 | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | |
| 姓名 | |  | 性别 | | | |  | 民族 | | | |  | | | 出生  年月 | | |  | | | | 年龄 | | | | | | | | | 岁 | | |
| 学历  情况 | | 最高医学学历 | 毕业时间 | | | | 毕业学校 | | | | | | | | | | | 所学  专业 | | | | | | | 学制 | | | | | | 学位 | | |
|  |  | | | |  | | | | | | | | | | |  | | | | | | |  | | | | | |  | | |
| 专业工作技情术况 | | 参加工作时间 | 执业医师类别  （具有医师资格人员填写） | | | | | | | | | | | | | | | 现任专业  技术职务 | | | | | | | | | | | | | 何时何单位聘任（任命） | | | | | | |
|  |  | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | |
| 从事本专业工作年限 | | | | | 现有专业技术职务任职资格 | | | | | | | | | | | 考取中级资格时间及审批机关 | | | | | | | | | | | | | | | | | | | |
|  | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| 任期考核结果 | | 2013年 | | | | 2014年 | | | | | | | 2015年 | | | | | | 2016年 | | | | | | | | 2017年 | | | | | | | | 2018年 | | |
|  | | | |  | | | | | | |  | | | | | |  | | | | | | | |  | | | | | | | |  | | |
| 外语考  试成绩 | | 合格 | | 不合格 | | | | | 放宽 | | | | | 免试 | | | 计算机考试成绩 | | | | 合格 | | | | | | | 不合格 | | | | | 放宽 | | | | 免试 |
|  | |  | | | | |  | | | | |  | | |  | | | | | | |  | | | | |  | | | |  |
| 继续医学  教育学分 | | 总分 | | | 其中Ⅰ类 | | | | | | 2013年 | | | | | 2014年 | | | | 2015年 | | | | 2016年 | | | | | | | | 2017年 | | | | 2018年 | |
|  | | |  | | | | | |  | | | | |  | | | |  | | | |  | | | | | | | |  | | | |  | |
| 到县或乡卫生机构情况 | | 累计服务时间（计算到天） | | | | | | | | | | | | | | | | | | | | | | | | | | | 不需具备 | | | | | | | | |
| 大写： 年 月 天 小写 （天） | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| 主  要  论  文  专  著  及  科  研  项  目  情  况 | 题 目 | | | | | | | | | | | | | | | | | 刊物名称（年、月、期、卷） | | | | | | | | | | | | 角 色 | | | | | | | |
|  | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | |
| 科室意见及支部意见 | （签字或盖章）    年 月 日 | | | | | | | | | 护理部意见（护士） | | （签字或盖章）    年 月 日 | | | | | | | | | | | 单位意见 | | | （签字或盖章）    年 月 日 | | | | | | | | | | | |