附件2

**与门诊特殊慢性病相关的医务人员信息汇总表**

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| --- | --- | --- | --- | --- | --- |
| 填表人： 填表日期： 年 月 日 单位名称： （公章） | | | | | |
| 姓名 | 科别 | 职称 | 执业医师（药师、护士）证号 | 身份证号 | 执业范围 |
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