昆明市“开口腔诊所”主题事项申请登记表

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **基础信息** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申请事项类型 | | | | □诊所执业备案（新办）  □医师执业首次注册  □医师执业变更注册  □医师多机构执业备案  □护士执业注册(首次注册）  □护士执业注册（变更注册）  □放射源诊疗技术和医用辐射机构许可（新办） | | | | | | | | | | | | | | | | | | | | | | | | |
| **市场主体信息** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 诊所名称： | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 诊所地址： | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 设置单位名称： | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 设置单位资质证明 | | | | 资质证书  名称 | | | |  | | | | | | | | | | | | | | | | | | | | |
| 资质编号 | | | |  | | | | | | | | | | | | | | | | | | | | |
| 设置人 | | | | 姓名 | | | |  | | | | | 联系电话 | | | | | | | | | |  | | | | | |
| 身份证号 | | | |  | | | | | | | | | | | | | | | | | | | | |
| **法定代表人信息** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 姓名 | | |  | | | | | | | | | 联系电话 | | | | | | | | |  | | | | | | | |
| 执业类别 | | |  | | | | | | | | | 执业范围 | | | | | | | | |  | | | | | | | |
| 身份证号 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医师资格证书编码 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医师执业证书编码 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **主要负责人信息** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 姓名 | | |  | | | | | | | | | 联系电话 | | | | | | | | |  | | | | | | | |
| 执业类别 | | |  | | | | | | | | | 执业范围 | | | | | | | | |  | | | | | | | |
| 身份证号 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医师资格证书编码 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医师执业证书编码 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **委托人信息** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 姓名 | | |  | | | | | 移动电话 | | | | | | | | | | | | |  | | | | | | | |
| 证件类型 | | |  | | | | | 证件号 | | | | | | | | | | | | |  | | | | | | | |
| 委托期限 | | | 自\_\_\_\_\_\_\_年\_\_\_\_月\_\_\_\_日至\_\_\_\_\_\_\_年\_\_\_\_月\_\_\_\_日 | | | | | | | | | | | | | | | | | | | | | | | | | |
| **诊所执业备案（必填)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **人员情况** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 其他医师  （可另附页） | | | 姓名 | | |  | | | | 执业  类别 | | | | |  | | | | | | 执业  范围 | | | | |  | | |
| 身份证号 | | |  | | | | | | | | | | | | | | | | | | | | | | |
| 医师资格证书编码 | | |  | | | | | | | | | | | | | | | | | | | | | | |
| 医师执业证书编码 | | |  | | | | | | | | | | | | | | | | | | | | | | |
| 护士  （可另附页） | | | 姓名 | | | 专业 | | | | 身份证号 | | | | | | | | | | | 执业证书编码 | | | | | | | |
|  | | |  | | | |  | | | | | | | | | | |  | | | | | | | |
| 药学人员  （可另附页） | | | 姓名 | | | 专业 | | | | 身份证号 | | | | | | | | | | | 执业证书编码  （或其他资质证书编码） | | | | | | | |
|  | | |  | | | |  | | | | | | | | | | |  | | | | | | | |
| 医技人员  （可另附页） | | | 姓名 | | | 专业 | | | | 身份证号 | | | | | | | | | | | 资格证书编码 | | | | | | | |
|  | | |  | | | |  | | | | | | | | | | |  | | | | | | | |
| **诊所情况** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 所有制形式 | | | □全民 □集体 □股份制 □私人 □其他 | | | | | | | | | | | | | | | | | | | | | | | | | |
| 经营性质 | | | □营利性 □非营利性（政府办） □非营利性（非政府办） | | | | | | | | | | | | | | | | | | | | | | | | | |
| 诊所类型 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 诊疗科目 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| 服务方式 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **医师执业首次注册、变更注册、多机构备案基本信息（必填)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 照片 | | 姓名 | |  | | | | 性 别 | | |  | | | | | | | | | 民 族 | | | | | | | |  |
| 出生日期 | |  | | | | | | | 专业技术职务任职资格 | | | | |  | | | | | | | | | | | | |
| 身份证号 | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 所学系、专业 | |  | | | | | | | 学 历 | | | | |  | | | | | | | | | | | | |
| 家庭地址及邮编 | | | |  | | | | | | | | | | | | | | | 健康状况 | | | | | |  | | | |
| 业务水平考核机构或组织名称、考核培训时间及结果 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 何时何地因何种原因受过何种处罚或处分 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 其他要说明  的问题 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| **个人工作经历** | | | | 时间 | | | | 单位 | | | | | | | | | 技术职务 | | | | | | | | | | 证明人 | |
|  | | | |  | | | |  | | | | | | | | |  | | | | | | | | | |  | |
|  | | | |  | | | |  | | | | | | | | |  | | | | | | | | | |  | |
| **医师执业首次注册** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申请执业级别 |  | | | | 申请执业类别 | |  | | | | | | | 申请执业  范围 | | | | | | | |  | | | | | | |
| 申请执业机构名称 |  | | | | | | | 执业机构  登记号 | | | | | |  | | | | | | | | | | | | | | |
| 申请执业机构地址 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 邮政编码 |  | | | | 单位  电话 | |  | | | | | | | 拟在该机构执业时间 | | | | | | | | | |  | | | | |
| 本人意见 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 拟执业机构  意见 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **医师执业变更注册** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 拟变更注册事项: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申请变更注册理由: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 原执业级别 |  | | | | 原执业类别 | |  | | | | | | | 原执业范围 | | | | | | | | | |  | | | | |
| 原执业机构  名称 |  | | | | 机构登记号 | |  | | | | | | | 单位  电话 | | | | | | | | | |  | | | | |
| 邮政编码 |  | | | | 地址 | |  | | | | | | | | | | | | | | | | | | | | | |
| 拟执业级别 |  | | | | 拟执业类别 | |  | | | | | | | 拟执业范围 | | | | | | | | | |  | | | | |
| 拟执业机构  意见 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **医师多机构备案** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 拟执业机构  名称 |  | | | | | | | 机构登记号 | | | | | |  | | | | | | | | | | | | | | |
| 机构地址 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 邮政编码 |  | | | | | | | 单位电话 | | | | | |  | | | | | | | | | | | | | | |
| 有效期开始时间 |  | | | | | | | 有效期结束时间 | | | | | |  | | | | | | | | | | | | | | |
| 拟执业机构  意见 |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **护士执业注册（必填)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 姓 名 | | | |  | | | | 性 别 | | | | |  | | | | | | | | | | 照片 | | | | | |
| 出生日期 | | | |  | | | | 民 族 | | | | |  | | | | | | | | | |
| 国 籍 | | | |  | | | | 健康状况 | | | | |  | | | | | | | | | |
| 通过护士执业  考试时间 | | | |  | | | | 是否首次注册 | | | | | 囗是 囗否 | | | | | | | | | |
| 证件类型 | | | |  | | | | 证件号码 | | | | |  | | | | | | | | | | | | | | | |
| 毕业时间 | | | |  | | | | 毕业学校 | | | | |  | | | | | | | | | | | | | | | |
| 专 业 | | | |  | | | | 学 制 | | | | |  | | | | | | | | | | | | | | | |
| 学 历 | | | |  | | | | 学 位 | | | | |  | | | | | | | | | | | | | | | |
| 参加工作时间 | | | |  | | | | 手机号码 | | | | |  | | | | | | | | | | | | | | | |
| **现执业机构** | | | |  | | | | 工作电话 | | | | |  | | | | | | | | | | | | | | | |
| 单位登记号 | | | |  | | | | 邮政编码 | | | | |  | | | | | | | | | | | | | | | |
| 行政区划 | | | | 省（自治区/直辖市） 市（地区） 区（县） | | | | | | | | | | | | | | | | | | | | | | | | |
| 现工作科室 | | | |  | | | | 技术职称 | | | | |  | | | | | | | | | | | | | | | |
| 现工作类别 | | | |  | | | | 职 务 | | | | |  | | | | | | | | | | | | | | | |
| **拟执业机构** | | | |  | | | | 工作电话 | | | | |  | | | | | | | | | | | | | | | |
| 单位登记号 | | | |  | | | | 邮政编码 | | | | |  | | | | | | | | | | | | | | | |
| 行政区划 | | | | 省（自治区/直辖市） 市（地区） 区（县） | | | | | | | | | | | | | | | | | | | | | | | | |
| 拟工作科室 | | | |  | | | | 技术职称 | | | | |  | | | | | | | | | | | | | | | |
| 拟工作类别 | | | |  | | | | 职 务 | | | | |  | | | | | | | | | | | | | | | |
| 何时何地因何种原因受过何种奖励或表彰 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| 何时何地因何种原因受过何种处罚或处分 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| 其他要说明的问题 | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **放射源诊疗技术和医用辐射机构许可（必填)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 机构总人数 | | |  | | | | | | | 放射工作人员数 | | | | | | | | | | |  | | | | | | | |
| 申  请  许  可  项  目 | X射线影像诊断 □  1、X射线CT影像诊断 □ 2、乳腺X射线影像诊断 □  3、CR影像诊断 □ 4、普通X射线机影像诊断 □  5、DR影像诊断 □ 6、牙科X射线影像诊断 □  7、其他X射线影像诊断 □ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 介入放射学 □  1、DSA介入放射诊疗 □ 2、其他影像设备介入放射诊疗 □ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 核医学□  1、PET影像诊断 □ 2、γ骨密度测量□  3、CT- PET影像诊断 □ 4、籽粒插植治疗 □  5、SPECT影像诊断 □ 6、放射性药物治疗 □  7、γ相机影像诊断 □ 8、其它核医学诊疗项目□ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 放射治疗 □   1. 立体定向（X刀）治疗 □ 2、钻--60机治疗 □   3、立体定向 (Y刀)治疗□ 4、后装治疗 □  5、医用加速器治疗 □ 6、深部X射线机治疗 □  7、质子治疗 □ 8、敷贴治疗 □  9、中子治疗□ 10、重离子治疗□  11、其他放射治疗项目 □ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 射线装置 | 科室名称 | | |  | | | | | 科室人员数 | | |  | | | | | | 放射工作人员数 | | | | | | |  | | | |
|  | | |  | | | | |  | | |  | | | | | |  | | | | | | |  | | | |
| **保 证 申 明**  本申请人和签字人承诺如下，并承担相应的法律责任。   1. 填报的信息及提交的材料真实、准确、有效、完整。 2. 严格按照备案的诊疗科目、技术开展诊疗活动，不开展超出备案范围的诊疗活动。   （三）法定代表人及主要负责人无以下情形：  1.不能独立承担民事责任的单位；  2.正在服刑或者不具有完全民事行为能力的人；  3.发生二级以上医疗事故未满5年的医务人员；  4.因违反有关法律、法规和规章，已被吊销执业证书的医务人员；  5.被吊销《医疗机构执业许可证》的医疗机构法定代表人或者主要负责人。  申请人承诺：本申请书中所填内容及所附资料均真实、合法、有效，复印文本均与原件一致。如有不实之处，本人（单位）愿负相应的法律责任，并承担由此产生的一切后果。  申请人（被委托人）签字（盖章）：  年 月 日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |