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| 附件2： |  |  |  |  |  |  |  |  |  |
| **康复医师花名册** | | | | | | | | | |
| 医疗机构名称（加盖公章）： 日期： | | | | | | | | | |
| 序号 | 姓名 | 性别 | 身份证号 | 执业资格类别 | 执业类别 | 执业范围 | 主要执业机构 | 卫生专业技术资格 | 备注 |
| 1 |  |  |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |  |  |
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| 联系人： 联系电话： | | | | | | | | | |