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| 附件3： |  |  |  |  |  |  |
| **康复治疗师花名册** | | | | | | |
| 医疗机构名称（加盖公章）： 日期： | | | | | | |
| 序号 | 姓名 | 性别 | 身份证号 | 卫生专业技术资格 | | 备注 |
| 级别 | 专业 |
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| 联系人： 联系电话： | | | | | | |