附件

会理市妇幼保健院医务人员需求个人登记表

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| **姓 名** | | |  | | **性别** |  | **民族** |  | **出生年月** |  | **照片** |
| **身份证号码** | | |  | | | | **婚否** |  | **学历/学位** |  |
| **籍 贯** | | |  | | **政治面貌** | |  | | **报名岗位** |  |
| **家庭住址** | | |  | | | | | | **联系电话** |  |
| **资格证名称** | | |  | | | | | | **个人特长** |  | |
| **学习经历** | **起止年月** | | | **就读院校** | | | **专 业** | | **是否全日制** | **学历** | **学 位** |
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| **工作经历** | **起止年月** | | | **工作单位** | | | **科 室** | | **岗位或职务** | | **备 注** |
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| **奖惩情况** |  | | | | | | | | | | |
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| **其他需要说明的情况（如陈述自己能够胜任此岗位所具备的专业知识储备和综合能力素质等）：** | | | | | | | | | | | |
| **本人对以上填写内容的真实性负责，并承担因填报虚假信息而产生的一切后果。** | | | | | | | | | | | |
|  |  |  |  |  |  |  |  | **本人签名：** | | | |