附件：

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| **“2023年医学专业教师教学能力与核心素养提升研修班”报名回执** | | | | | | | | | |
| 单位 |  | | | | | | | | |
| 地址 |  | | | | | | | 邮编 |  |
| 联系人 |  | | | | | | | 联系电话 |  |
| 参会 代表 | 姓名 | | 性别 | 科室 | 职称/职务 | 身份证号 | 手机 | 电子邮箱 | |
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| 8 |  | |  |  |  |  |  |  | |
| 单位名称 | |  | | | | | | | |
| 纳税人识别号 | |  | | | | | | | |