附件2

**2023年附属医院同等学力符合条件申请人员名单**

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| **序号** | **附属医院名称** | **姓名** | **一级学科 （临床医学/口腔）** | **二级学科** | **电话** | **身份证号** |
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| **审批人签字： 审批单位盖章：   审批时间： （科教科/教学办）** | | | | | | |