附件3

**医疗美容机构评价试点**

**申报书**

**申报单位（盖章）：**

**申报日期：**

**中国整形美容协会 制**

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| 一、基本情况 | | | | | | | | | | | | | | | |
| 机构名称 | | |  | | | | | | | | | | | | |
| 地 址 | | |  | | | | | | | | | 邮政编码 | | |  |
| 联系电话 | | |  | | | | | | | 传真电话 | |  | | | |
| 机构实际开放床位数 | | | |  | | | | 机构业务用房建筑面积 | | | | | | m2 | |
| 机构人数（有四险一金人员） | | | 人，其中卫生技术人员数 人，管理人员数 人； | | | | | | | | | | | | |
| 法定代表人 | | |  | | | 联系电话 | | | （办）： （手机）： | | | | | | |
| 主要负责人 | | |  | | | 电子邮箱 | | |  | | | | | | |
| 联系电话 | | | （办）： （手机）： | | | | | | | | | | | | |
| **（一）技术队伍情况** | | | | | | | | | | | | | | | |
| **1．医师人员一览表** | | | | | | | | | | | | | | | |
| 姓 名 | 性别 | 出生年月 | | | 学历学位 | | 职称 | 专 业 | | | 从事本专业年限 | | 学术团体及杂志担任职务 | | |
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注：人员较多，可另附页。

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| **2．护理人员一览表** | | | | | | | | | | | | | | | | | | | |
| 姓 名 | 性别 | | 出生年月 | | | 学历学位 | 职称 | | | 专 业 | | | 从事本  专业年限 | | | 学术团体及  杂志担任职务 | | | |
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| **3．职称结构** | | | | | | | | | | | | | | | | | | | |
|  | | | | 总 计  人 数 | | | | 职称分类 | | | | | | | | | | | |
| 正高级 | | | 副高级 | | | 中 级 | | | 初 级 | | |
| 合 计 | | | |  | | | |  | | |  | | |  | | |  | | |
| 卫 生  技 术  人 员 | | 小 计 | |  | | | |  | | |  | | |  | | |  | | |
| 医 师 | |  | | | |  | | |  | | |  | | |  | | |
| 护 士 | |  | | | |  | | |  | | |  | | |  | | |
| 技术人员 | |  | | | |  | | |  | | |  | | |  | | |
| 管理人员 | | | |  | | | |  | | |  | | |  | | |  | | |
| 其 他 | | | |  | | | |  | | |  | | |  | | |  | | |
| **（二）医疗服务能力和水平** | | | | | | | | | | | | | | | | | | |
| **1.常规技术** | | | | | | | | | | | | | | | | | | |
| 常规技术名称 | | | | | 近五年开展例数 | | | | | | | | | | | | | |
| 年 | | | | 年 | | | 年 | | | 年 | | | 年 |
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注：常规技术较多，可另附页。

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| **2.重点技术** | | | | | |
| 重点技术名称 | 近五年开展例数 | | | | |
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| **3.特色技术** | | | | | |
| **特色技术名称** | 近五年开展例数 | | | | |
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| 特色技术先进性 | | | | |
| □国内最早 □国际最早 □国内领先 □国际领先 | | | | |
| 特色技术应用情况说明： | | | | | |
| **特色技术名称** | 近五年开展例数 | | | | |
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| 特色技术先进性 | | | | |
| □国内最早 □国际最早 □国内领先 □国际领先 | | | | |
| 特色技术应用情况说明： | | | | | |

注：特色技术项目较多，可另附页。

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| **4.近五年新技术、新业务** | | | | | | | | | | | | | | |
| 新技术新业务名称 | | | 开展年度 | | | 开展例数 | 新技术新业务先进性 | | | | | | | |
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| **（三）人才培养** | | | | | | | | | | | | | | |
| **1．近五年派出学历学位教育情况** | | | | | | | | | | | | | | |
| 姓 名 | 在职深造  学历学位 | | | 在读院校（国内、外） | | | | | | 学习年限 | | | 毕业年月 | |
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| **2．近五年派出进修培训** | | | | | | | | | | | | | | |
| 姓 名 | 在何单位进修 | | | | | | | 进修专业 | | | | 进修时间  （年月～年月） | | |
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| **3．上年度派出参加国家级或省级继续医学教育项目情况** | | | | | | | | | | | | | | |
| 姓 名 | 参加继续教育项目名 | | | | | | | 继续项目类别 | | | | 学习时间  （年月～年月） | | |
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| **（四）设备及配套** | | | | | | | | | | | | | | |
| **1．专用设备** | | | | | | | | | | | | | | |
| 仪器设备名称 | | 型号规格 | | | 生产厂家 | | | | 购买  日期 | | 金额（万元） | | | 运行状况 |
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| **2．相关科室配套设施** | | | | | | | | | | | | | | |
| 仪器设备名称 | | 型号规格 | | | 生产厂家 | | | | 购买  日期 | | 金额（万元） | | | 使用情况 |
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| **真实性声明：**  本人承诺所提供的资料真实、有效，愿意承担全部法律责任。  医疗机构法定代表人（签字）：  单位公章  年 月 日 | | | | | | | | | | | | | | |
| **单位意见：**  负责签字人：  （单位公章）  年 月 日 | | | | | | | | | | | | | | |
| **省级医疗美容社会组织（委托的医疗美容评价机构）初评意见：**    负责签字人：  （单位公章）  年 月 日 | | | | | | | | | | | | | | |
| **专家组评审意见：**  负责签字人：  年 月 日 | | | | | | | | | | | | | | |