**杭州医学院实习工作会议暨校外实践教学基地签约仪式回执**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **姓 名** |  | **性别** |  | **职务** |  | | | **职称** | |  |
| **工作单位** |  | | | | | | | | | |
| **通讯地址** |  | | | | | | | **邮编** | |  |
| **联系电话** | **办公：**  **手机：** | | | | **E-mail** | |  | | | |
| **是否住宿** |  | **入住日期** | |  | | **离会日期** | | |  | |
| **住宿标准**  **（请注明独住、合住或其它要求** | |  | | | | **是否带司机** | | |  | |

**注：回执复印有效。回执邮寄地址：杭州市滨江区滨文路481号杭州医学院实践教学中心。电子版回执请发至邮箱27931878@qq.com**

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