附件2

PICC专科护理门诊建设运营专业能力培训  
参会回执

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **单位名称** | |  | | | | | |
| **联系人姓名** | |  | | **职务** | |  | |
| **手机号** | |  | | **职称** | |  | |
| **电子邮箱** | |  | | | | | |
| **备注** | |  | | | | | |
| **以下填写同单位参培人员** | | | | | | | |
| **序号** | **姓名** | | **身份证号** | | **职务** | | **联系方式** |
| **1** |  | |  | |  | |  |
| **2** |  | |  | |  | |  |
| **3** |  | |  | |  | |  |

咨询及报名联系人：

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