附件：

**中国非公立医疗机构协会**

**专业能力培训项目申报审批表**

培训项目名称：

项目申报机构：

填报日期：

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| **培训项目必要性分析** |
| （包括背景、技术介绍、市场需求、培训对象、受众数量、前期开展情况、与产业结合的方式） |
| **项目中其他合作方与合作方式介绍** |
| （是否有政府主管部门、其他行业NGO组织、医学院校、医疗机构、产业园区、海外机构的合作，是否需要协会签订相应的合作协议） |

**表1-项目基本情况表**

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| **项目承接运营方介绍** |
| 机构简介、经济实力、过往项目经验等 |
| **项目关键要素** |
| 是否开展师资培训颁发师资证书、是否设立培训基地颁发基地铜牌、是否建立项目专网与官微、培训结束后是否由协会培训证书、培训证书年检的方式（例如要求年度上传病例数量）等情况的说明 |
| **项目经费** |
| （项目运转三年收入与支出预算  是否有企业赞助，目前意向企业与意向赞助额度，年度招商计划  是否面向学员收费，收费区间，年度招生计划） |

**表2-项目教学资源情况**

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| **2-1项目师资团队** | | | | | | | | | | | | | | |
| 姓名 | | 单位 | | | 手机 | | | | | | | | 职称 | 职务 |
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| **2-2拟设基地意向** | | | | | | | | | | | | | | |
| 是否设立基地 | | | □是 □否 | | | | | | | | | | | |
| 序号 | | | 拟设立基地名称 | | | | | | | | | | | |
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| 8 | | |  | | | | | | | | | | | |
| 9 | | |  | | | | | | | | | | | |
| **2-3培训课程策划** | | | | | | | | | | | | | | |
| **培训对象** | | |  | | | | | | | | | | | |
| **远程课程** | 远程培训类型：  包括大班直播课程、小班直播课程、录播课程等； | | | | | | | | | | | | | |
| **课程名称** | | | | | | | | **教师** | | | **类型** | | **学时** |
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| **面授课程** | 面授培训类型：  包括学术讲座、专题讨论、技能操作演示、模拟训练等 | | | | | | | | | | | | | |
| **课程名称** | | | | | | | **教师** | | **类型** | | | | **学时** |
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| **临**  **床实践** | 临床实践类型：  包括手术观摩、教学查房、实习小讲座、病例讨论等。 | | | | | | | | | | | | | |
| **课程名称** | | | | |  | | | | | **类型** | | | **学时** |
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| **2-4学习过程考核** | | | | | | | | | | | | | | |
| 面授签到频率 | | | /天 | 实践操作签到频率 | | | | | | | | | | /天 |
| 在线学习测评次数 | | | 次 | 面授项目考核方式 | | | | | | | | | |  |
| 其他考核方式 | | |  | | | | | | | | | | | |

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| **专家评审意见** | **签字 年 月 日** |
| **中国非公立医疗机构协会**  **学术培训部评审意见** | **签字 年 月 日** |
| **中国非公立医疗机构协会** | **盖章 年 月 日** |

**表3-评审与复核意见**

附件3

**培训基地（中心）申请表**

**填 表 说 明**

请依据《中国非公立医疗机构协会培训基地（中心）管理办法》（以下简称“管理办法”）逐项认真填写本申报表，所填内容必须真实、准确，不得漏填、误填。

申报表须由所在单位签署意见并加盖章。

若表内填写不完，可用同样大小的纸续写。

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| 申请单位： |  |
| 专业/学科： |  |
| 基地名称： |  |
| 申报方式： | □ 直接申报 □通过分支机构申报 |
| 培训基地（中心）负责人： |  |
| 申请日期： |  |

**中国非公立医疗机构协会**

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| **申请单位基本情况** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申请单位名称 | | | | |  | | | | | | | | | | | | | | | | | | | | 邮政编码 | | | | | | |  | | |
| 地址 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 类别 | | | | | □综合医院 | | | | | | | | □专科医院 | | | | | | | □附属医院 | | | | □教学医院 | | | | | | | | | | |
|
| 等级 | | | | | □三级甲等 | | | | | | | | □其它三级 | | | | | | | □二级甲等 | | | | □其他： | | | | | | | | | | |
| 注册登记类型 | | | | | □公立医院 | | | | | | | | 社会办医: □私营医院 □联营医院 □外资医院 | | | | | | | | | | | | | | | | | | | | | |
| 管理方式 | | | | | □营利 □非营利 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 申报培训基地（中心）名称 | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **培训负责科室基本情况** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 科室负责人姓名： | | | | | | | | | | | | | | | | | | | | | | | | | Email： | | | | | | | | | |
| 项目负责人姓名 | | | | | | | 出生年月 | | | | | | | | | | 学历/学位 | | | | | | 职称 | | | | | | | | 联系电话 | | | |
|  | | | | | | |  | | | | | | | | | |  | | | | | |  | | | | | | | |  | | | |
| 负责人通讯地址 | | | | | | | | | | | | | | | 邮政编码 | | | | | | | | 手机 | | | | | | | | 办公室电话 | | | |
|  | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | |  | | | |
| 专职管理人员姓名： | | | | | | | | | | 联系电话： | | | | | | | | | | | | | | | Email： | | | | | | | | | |
| 科室执业人员总人数： | | | | | | | | | | 高级职称： 人 中级职称： 人 | | | | | | | | | | | | | | | | | | | | | | | | |
| 初级职称： 人 技师： 人 护士： 人 | | | | | | | | | | | | | | | | | | | | | | | | |
| 科室编制总床位数 | | | | | 张 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **培训负责科室人员构成** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | 初级 | | | | | | | | 中级 | | | | | | | | | | 副高 | | | | | | | 高级 | | | | | | |
| 医师 | | |  | | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | |
| 护士 | | |  | | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | |
| 技师 | | |  | | | | | | | |  | | | | | | | | | |  | | | | | | |  | | | | | | |
| 年门诊量 | | | | | 人次/年 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 年住院量 | | | | | 人次/年 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| （1） （专项相关技术或手术名称） | | | | | | | | | | | | | | | | | | | | | | | | | | | | 人次/年 | | | | | | |
| （2） （专项相关技术或手术名称） | | | | | | | | | | | | | | | | | | | | | | | | | | | | 人次/年 | | | | | | |
| （3） （专项相关技术或手术名称） | | | | | | | | | | | | | | | | | | | | | | | | | | | | 人次/年 | | | | | | |
| （4） （专项相关技术或手术名称） | | | | | | | | | | | | | | | | | | | | | | | | | | | | 人次/年 | | | | | | |
| （5） （专项相关技术或手术名称） | | | | | | | | | | | | | | | | | | | | | | | | | | | | 人次/年 | | | | | | |
| （6） （专项相关技术或手术名称） | | | | | | | | | | | | | | | | | | | | | | | | | | | | 人次/年 | | | | | | |
| （7） （专项相关技术或手术名称） | | | | | | | | | | | | | | | | | | | | | | | | | | | | 人次/年 | | | | | | |
| （8） （专项相关技术或手术名称） | | | | | | | | | | | | | | | | | | | | | | | | | | | | 人次/年 | | | | | | |
| （9） （专项相关技术或手术名称） | | | | | | | | | | | | | | | | | | | | | | | | | | | | 人次/年 | | | | | | |
| **培训科室负责人和骨干简历（学历、工作经历、培训经历、职称、社会兼职、近5年承担的市级或以上的课题、发表的相关专业领域的代表性论文）** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **学历：**  **工作经历：**  **社会任职：**  **近5年的学术发表：** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **培训师资队伍** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 姓名 | 职称 | | | | | 手机号 | | | | | | 从事本专业年限 | | | | | | | 教学经验年限 | | | | | | | 社会兼职 | | | | | | | | |
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| **申请培训项目内容** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **培训项目名称** | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| 培训时间 | | | | | |  | | | | | | | | | | | | 培训方式 | | | | | | | | |  | | | | | | | |
| **培训大纲** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 内容 | | | | | |  | | | | | | | | | | | | 使用教材 | | | | | | | | |  | | | | | | | |
| 内容 | | | | | |  | | | | | | | | | | | | 使用教材 | | | | | | | | |  | | | | | | | |
| 内容 | | | | | |  | | | | | | | | | | | | 使用教材 | | | | | | | | |  | | | | | | | |
| 内容 | | | | | |  | | | | | | | | | | | | 使用教材 | | | | | | | | |  | | | | | | | |
| 内容 | | | | | |  | | | | | | | | | | | | 使用教材 | | | | | | | | |  | | | | | | | |
| 内容 | | | | | |  | | | | | | | | | | | | 使用教材 | | | | | | | | |  | | | | | | | |
| 内容 | | | | | |  | | | | | | | | | | | | 使用教材 | | | | | | | | |  | | | | | | | |
| **申报单位的资质情况** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 医疗结构的类型 | | | | | | □医疗机构 □咨询服务机构 □企业内训机构 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 国家临床重点学科 | | | | | | | | | | | | | | | | | | | | | | | | | □是 □否 | | | | | | | | | |
| 省市重点建设学科 | | | | | | | | | | | | | | | | | | | | | | | | | □是 □否 | | | | | | | | | |
| 学位培养点 | | | | | | | | | | | | | | | | | | | | | | | | | □是 □否 | | | | | | | | | |
| 是否质控中心所在单位 | | | | | | | | 省质控中心 □是 □否 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 市质控中心 □是 □否 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 正在承担的继续教育项目 | | 级别 | | | | | | | | | | | | | 名称 | | | | | | | | | | | | | | | | | | | 培训人数 |
| □国家 □省 □市 □院 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  |
| □国家 □省 □市 □院 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  |
| □国家 □省 □市 □院 | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  |
| **培训科室基本条件** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 近三年是否发生重大医疗事故 | | | | | | | | | | | | | | | | | | | □有 □无 | | | | | | | | | | | | | | | |
| 近三年质量评估是否合格 | | | | | | | | | | | | | | | | | | | □是 □否 | | | | | | | | | | | | | | | |
| 曾应培训获得哪些奖励 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **培训用设备** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 设备种类和数量（可附页） | | | | 设备名称 | | | | | | | | | | | | | | | | | | 品牌 | | | | | | | | | | | 数量 | |
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| **培训硬件设施** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 教室面积 | | | | | |  | | | | | | | | | | 可容纳人员 | | | | | | | | | | | |  | | | | | | |
| 电化教学设备情况（名称、数量，可另附表） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 模拟操作场地面积 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **培训目标** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 培训对象： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 预计每年可接纳的学员数量 | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | |
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| **培训基地（中心）的既往培训经验** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 已经建立的培训相关的规章制度  （可另附页） | | | | 相关专业管理组织架构 | | | | | | | | | | | | | | | | | | | | | | | | | | □有 □无 | | | | |
| 相关规范、标准化操作流程 | | | | | | | | | | | | | | | | | | | | | | | | | | □有 □无 | | | | |
| 课程表 | | | | | | | | | | | | | | | | | | | | | | | | | | □有 □无 | | | | |
| 学员档案 | | | | | | | | | | | | | | | | | | | | | | | | | | □有 □无 | | | | |
| 师资管理档案（资质、师资培训、师资岗位责任） | | | | | | | | | | | | | | | | | | | | | | | | | | □有 □无 | | | | |
| 培训质量跟踪体系 | | | | | | | | | | | | | | | | | | | | | | | | | | □有 □无 | | | | |
| **其他需要说明的事项** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 申报单位意见： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| （单位盖章）  年 月 日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 审批单位意见： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| （盖章）  中国非公立医疗机构协会  年 月 日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

请附：1.申请机构医疗执业许可证复印件；2.申请机构事业单位法人证书复印件；

3.申请机构组织机构代码证复印件；4.申请机构法人代表身份证复印件。