附件2：

**学分登记通讯录**

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| **姓名** | **年龄** | **性别** | **职称** | **工作单位（注：请填写单位标准全称）** | **是否来自基层****（县及以下、社区等医疗卫生机构）** | **单位****所在地** | **授予学分** | **联系电话** |
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