**全国医学研究生教育与培养质量提升研讨会暨研究生导师培训会**

**注册回执表**

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| 单位名称 |  | | | 联 系 人 |  |
| 通信地址 |  | | | 联系电话 |  |
| 姓 名 | 性别 | 职务/职称 | （移动）电话 | 电子邮箱 | |
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| 住宿预订 | 标间单住　○ 标间合住　○ | | | | |
| 备 注 |  | | | | |

此表复印有效请务必认真填写。