**“FJO—JHU骨科医生高级教育项目”申请表**

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| **姓名** |  | | **性别** | |  | | **年龄** | |  | | **行政职务** | |  | | **照片** | |
| **职称** |  | | **学历** | |  | | | **骨科亚专科** | | | |  | | |
| **护照类型** | * **因公护照** * **因私护照** | | | **英语水平** | | | | | * **CET-6** * **雅思** * **托福** | | | * **优** * **良** * **好** | | |
| **护照号** |  | | | | **最后毕业院校** | | | | |  | | | | |
| **护照有效期** |  | | | | **单位名称** | | | |  | | | | | | | |
| **通讯地址** |  | | | | | | | | | | | | **邮编** |  | | |
| **手机** |  | | | | **固定电话** | | | |  | | | | **电子邮箱** | |  | |
| **微信号** |  | | | | **QQ** | | | |  | | | | **掌握何种外语** | | |  |
| **主要工作经历** | | **起止日期** | | | | **单位名称** | | | | | **职务名称** | | | | | |
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| **主要教育经历** | | **起止日期** | | | | **学 校** | | | | | **专 业** | | | | **学历/学位** | |
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| **主要研究方向** | | **① ② ③** | | | | | | | | | | | | | | |
| **临床工作专长**  **（少于100字）** | |  | | | | | | | | | | | | | | |
| **科室主任意见** | | **签名： 年 月 日** | | | | | | | | | | | | | | |
| **所在单位**  **负责人意见** | | **签名： 单位盖章： 年 月 日** | | | | | | | | | | | | | | |

**请严格如实填写表格，贴附一寸免冠近照，填完后将申请表发至电子邮箱：**[**muyali1985@163.com**](mailto:muyali1985@163.com) **纸质版邮寄至：陕西省西安市长乐西路127号西京医院骨科穆雅莉 13484628175**

**International College of Orthopaedic Education, the Fourth Military Medical University—JHU Advanced Orthopaedic Surgeons Educational Program Application Form**

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| Name |  | | Gender | |  | | Age |  | Administrative Post | |  | | Photo | |
| Title |  | | Degree | |  | | Subspecialty | |  | | | |
| Passport Type | | * Passport for Public * Passport for Private | | | | | English Proficiency | | * CET-6 * IELTS * TOFEL | * Excellent * Good * Fair | | |
| Passport No. | |  | | | Last Graduate School | | | |  | | | | | |
| Expiration Date | |  | | | Name of Institution | | | |  | | | | | |
| Correspondence Address | | | |  | | | | | | | | Zip Code |  | |
| Mobile | |  | | | Tel | | | |  | | | Email |  | |
| Wechat No. | |  | | | QQ | | | |  | | | Which language do you master? | |  |
| Work experience | | | Time Periods | | | Name of Institution | | | Title | | | | | |
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| Educational Background | | | Time Periods | | | School | | | Specialty | | | | Degree | |
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| Main Research  Interests | | | ① ② ③ | | | | | | | | | | | |
| Clinical Work  (Less than 100 words) | | |  | | | | | | | | | | | |
| Department Evaluation | | | Signature Date | | | | | | | | | | | |
| Institution  Evaluation | | | Signature Stamp Date | | | | | | | | | | | |

Please fill in the application form and send it to: [muyali1985@163.com](mailto:muyali1985@163.com)

Contact: Ms Mu Tel: 029—84773524 Wechat No. 13484628175