附件1

**济宁市基本医疗保险综合定点医疗机构**

**申 请 表**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **医疗机构名称** | |  | | | | | | | | | |
| **详细地址** | |  | | | | | | | | | |
| **联系人** | |  | | | **联系电话** | |  | | | | |
| **机构代码** | |  | | | **法人代表** | |  | | | | |
| **所有制形式** | |  | | | **机构类别** | |  | | | | |
| **机构级别和**  **等级** | |  | | | **床位数量** | |  | | | | |
| **诊疗科目** | |  | | | | | | | | | |
| **执业许可证号** | |  | | | **批准时间和**  **有效期限** | | |  | | | |
| **上年度业务**  **收入** | |  | | | **建筑面积** | | |  | | | |
| **卫生技术人员构成** |  | | **总人数** | **高级职称** | | **中级职称** | | **初级职称** | | **参加社会保险情况** | |
| **医 生** | |  |  | |  | |  | |  | |
| **护 理** | |  |  | |  | |  | |  | |
| **医技人员** | |  |  | |  | |  | |  | |
| **其他人员** | |  |  | |  | |  | |  | |
| **合计** | |  |  | |  | |  | |  | |
| **科室设置及病床数** | **科室** | | **床位数** | **科室** | | **床位数** | | | **科室** | | **床位数** | |
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| **申**  **请**  **内**  **容** | **（申请单位印章）**  **法人代表签字： 年 月 日** | | | | | | | | | | | |
| **医**  **疗**  **保**  **障**  **经**  **办**  **机**  **构**  **意**  **见** | **（印章）**  **负责人签字： 年 月 日** | | | | | | | | | | | |

附件2

**济宁市基本医疗保险门诊定点医疗机构**

**申 请 表**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **医疗机构名称** |  | | | | | | |
| **详细地址** |  | | | | | | |
| **联系人** |  | | | **联系电话** | |  | |
| **机构代码** |  | | | **法人代表** | |  | |
| **所有制形式** |  | | | **机构类别** | |  | |
| **诊疗科目** |  | | | **经营性质** | |  | |
| **大型仪器设备**  **名称和数量** |  | | | | | | |
| **执业许可证号** |  | | | **批准时间和**  **有效期限** | |  | |
| **上年度业务收入** |  | | | **建筑面积** | |  | |
| **卫生**  **技术**  **人员**  **构成** | |  | **总人数** | **高级职称** | **中级职称** | **初级职称** | **参加社会保险情况** |
| **医生** |  |  |  |  |  |
| **护理** |  |  |  |  |  |
| **医技人员** |  |  |  |  |  |
| **其他人员** |  |  |  |  |  |
| **合计** |  |  |  |  |  |
| **申**  **请**  **内**  **容** | | **（申请单位印章）**  **法人代表签字： 年 月 日** | | | | | |
| **医**  **疗**  **保**  **障**  **经**  **办**  **机**  **构**  **意**  **见** | | **（印章）**  **负责人签字： 年 月 日** | | | | | |

附件3

**济宁市基本医疗保险定点零售药店申请表**

|  |  |  |  |  |  |  |  |  |
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| **药店名称** |  | | | | | | | |
| **详细地址** |  | | | | | | | |
| **经营形式** | **连锁（ □ 直营、 □ 加盟）、 □单体** | | | | | | | |
| **药品经营许可证号码及批复时间** | | | |  | | | | |
| **负责人** |  | | | | | **联系电话** |  | |
| **工作人员** | **人** | **药 师** | **人** | | | **药店建筑面积** |  | |
| **上年度业务收入** | |  | | | | **药品品种** |  | |
| **工作人员参加社会保险情况** | | | | | | | | |
| **姓名** | **身份证号码** | | **养老** | | **医疗** | **工伤** | **失业** | **生育** |
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| **申**  **请**  **内**  **容** | **（申请单位印章）**  **法人代表签字： 年 月 日** | | | | | | | |
| **医**  **疗**  **保**  **障**  **经**  **办**  **机**  **构**  **意**  **见** | **（印章）**  **负责人签字： 年 月 日** | | | | | | | |

附件4

医疗机构从业人员名册

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **序号** | **姓名** | **身份证号** | **现从事专业** | **从业资格证书号码** | **参加医疗保险情况** |
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附件5

药店从业人员名册

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **序号** | **姓名** | **身份证号** | **现从事专业** | **从业资格证书号码** | **参加医疗保险情况** |
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