附件3

**全省定点医疗机构一线医务人员**

**慰问名单及标准**

填报单位： 年 月 日

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **序号** | **医院名称** | **慰问人员****姓名** | **所在科室** | **慰问金额（元）** | **备注** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

填报人： 联系电话：