**济宁市基本医疗保险综合定点医疗机构**

**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** | |  | | | | | |
| **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** | | | | | | | | | | |
| **社会保险经办机构意见** | **（印章）**  **负责人签字： 年 月 日** | | | | | | | | | | |