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| **科研协作门诊检查费申请** | | | | |
| **患者姓名** |  | **身份证号码** |  | |
| **合作单位** |  | | | |
| **项目名称** |  | | | |
| **研究进度** |  | | | |
| **本次检查项目** |  | | | |
| **合计费用** |  | | | |
| **申请人** |  | **机构办负责人** | |  |
| **日期** |  |  | |  |

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