附件7

家庭医生团队补助领取情况表

填报机构：（盖章） 机构负责人： 联系方式：

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 姓名 | 完成任务量（人） | 补助标准(元/人) | 补助资金（元） | 领取人签字确认 | 领取日期 | 备注 |
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