附件4

**《精益医疗管理规范》征求意见表**

\_\_\_\_\_\_\_\_\_\_省(自治区) \_\_\_\_\_\_\_市\_\_\_\_\_\_\_\_\_\_\_\_\_县（区）

机构名称：

医院级别： □A三级 □B二级 □C一级 □D未定级

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **序号** | **标准章条编号** | **姓名** | **职务/职称** | **意见及建议** | **修改依据** |
| **1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |
| **4** |  |  |  |  |  |
| **5** |  |  |  |  |  |
| **6** |  |  |  |  |  |
| **7** |  |  |  |  |  |
| **8** |  |  |  |  |  |
| **9** |  |  |  |  |  |
| **10** |  |  |  |  |  |