附件1

**函　件**

香港特别行政区政府香港警务处：

兹有你特区居民\_\_\_\_\_\_\_\_\_\_\_\_，港澳居民居住证（或港澳居民来往内地通行证）号码\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_，香港居民身份证号码\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_，于我省（区、市）申请认定教师资格。根据《教师资格条例》规定和《教育部办公厅中共中央台湾工作办公室秘书局国务院港澳事务办公室秘书行政司关于港澳台居民在内地（大陆）申请中小学教师资格有关问题的通知》（教师厅［2019］1号）要求，现需该居民提供无犯罪纪录证明，请你单位协助予以开具。

函复为盼。

联系人姓名及职衔：

办公室电话：

通信地址：

|  |  |
| --- | --- |
| 附件2 | 单位名称  单位盖章  20 年 月 日 |

**函　件**

澳门特别行政区政府身份证明局：

兹有你特区居民\_\_\_\_\_\_\_\_\_\_\_\_，港澳台居民居住证（或港澳居民来往内地通行证）号码\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_，澳门居民身份证号码\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_，于我省（区、市）申请认定教师资格。根据《教师资格条例》规定和《教育部办公厅中共中央台湾工作办公室秘书局国务院港澳事务办公室秘书行政司关于港澳台居民在内地（大陆）申请中小学教师资格有关问题的通知》（教师厅［2019］1号）要求，现需该居民提供“刑事纪录证明书”，请你单位协助予以开具，并将此证明书直接寄回我单位。

函复为盼。

联系人姓名及职衔：

办公室电话：

通信地址：

|  |  |
| --- | --- |
|  | 单位名称  单位公章  20 年 月 日 |

附件3

广东省教师资格申请人员体格检查表

（2013年修订）

市 县(区) 申请资格种类

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓 名 | | |  | | 性别 | | | | | |  | | | | | | | 年龄 | | | | | |  | | 民族 | | | | | |  | | | | 贴  相  片  处 | | | |
| 籍 贯 | | |  | | 身份证号码 | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 工作单位 | | |  | | | | | | | | | | | | | | | | | 职 业 | | | | | | | | |  | | | | | | |
| 通讯地址 | | |  | | | | | | | | | | | | | | | | | 联系电话 | | | | | | | | |  | | | | | | |
| 既往病史  （项目见说明） | | | 本人签名： | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (以上空白处由申请人如实填写) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 五官科 | 裸眼视力 | | | | 右 | | 矫正  视力 | | | | | | | | 右 | | | | | | | 矫正度数 | | | | 右 | | | | | | | | 医师意见:  签名: | | | | | |
| 左 | | 左 | | | | | | | 左 | | | | | | | |
| 辨色力 | | | |  | | | | | | | | | | 眼病 | | | | | | |  | | | | | | | | | | | |
| 听力 | | | | 左耳 　　　米 | | | | | | | | | | | | 右耳 米 | | | | | | | | | | | | | | | | |
| 鼻 | | | | 嗅觉 | | | |  | | | | | | | | 鼻及鼻窦 | | | | | | | | |  | | | | | | | |
| 面部 | | | |  | | | | | | | 咽喉 | | | | | | | | | | | | | |  | | | | | | | |
| 口腔唇腭 | | | |  | | | | | | | 齿 | | | | | | | | | | | | | |  | | | | | | | |
| 其他 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 外科 | 身高 | | | | 厘米 | | | | | | | 体重 | | | | | | | | | | | | | | | 千克 | | | | | | | 医师意见:  签名: | | | | | |
| 淋巴 | | | |  | | | | | | | 脊柱 | | | | | | | | | | | | | | |  | | | | | | |
| 四肢 | | | |  | | | | | | | 关节 | | | | | | | | | | | | | | |  | | | | | | |
| 皮肤 | | | |  | | | | | | | 颈部 | | | | | | | | | | | | | | |  | | | | | | |
| 其他 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 内科 | 血压 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 医师意见:  签名: | | | | | |
| 营养状况 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 心脏及血管 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 呼吸系统 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 神经系统 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 腹部器官 | | | | 肝 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 脾 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 其他 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 化验检查  (附化验单) | | 血常规 | | |  | | | | | | | 肝功五项  （谷草、谷丙转氨酶、胆红素三项） | | | | | | | | | | | | | | | | |  | | | | | 肾功三项 | | | |  | |
| 血糖 | | |  | | | | | | | 类风湿因子 | | | | | | | | | | | | | | | | |  | | | | | 尿常规 | | | |  | |
| 仅限申请幼儿教师资格 | | 淋球菌 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | 医师意见：  签名： | | | | | |
| 梅毒螺旋体 | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 妇科  检查 | | | 滴虫 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 念球菌 | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| 胸部透视 | | | | | 医师签名: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 体检结论 | | | | | 主检医生签名:  年 月 日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 体检医院  意 见 | | | | | 体检医院 盖章  年 月 日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | |  |  | |  | |  | |  | | |  |  | |  | | |  |  |  | |  | |  | | |  | |  |  | |  | |  | |  | |  | |

说明：既往病史指心脏病、肝炎、哮喘、精神病、癫痫、结核、皮肤病、性传播性疾病等病史。本人应如实填写患病时间、治愈等情况，否则后果自负。（**请用A4纸双面打印**）