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\_\_\_\_\_\_\_\_\_\_\_\_，港澳台居民居住证（或来往内地通行证）号码\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_，香港身份证号码\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_，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：

|  |  |
| --- | --- |
| 盖印 | \_\_\_\_\_\_\_省（区、市）教育厅（教委）  （\_\_\_\_\_\_\_省教师资格认定中心）  20XX年X月X日 |

附件2

**函　件**

澳门特别行政区身份证明局：

兹有你特区居民\_\_\_\_\_\_\_\_\_\_\_\_，港澳台居民居住证（或来往内地通行证）号码\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_，澳门身份证号码\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_，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：

|  |  |
| --- | --- |
| 盖印 | \_\_\_\_\_\_\_省（区、市）教育厅（教委）  （\_\_\_\_\_\_\_省教师资格认定中心）  20XX年X月X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**）