附件1

**教师资格证明**

兹证明 ，性别 ，身份证号： ，2023年申报 层次教师资格，申请任教学科： ，经资格初审和现场确认合格，教师资格证书正在申办中。

特此证明

教师资格认定机构印章

年 月 日

**照片粘贴、证书邮寄信息**

姓名：\_\_\_\_\_\_\_\_\_\_\_\_ 网报号：\_\_\_\_\_\_\_\_\_\_\_\_

身份证号：\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

联系电话：\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

证书邮寄地址：（是否与系统填报时地址一致请注明并填写邮寄地址，如申请人不希望邮寄证书，此处仅填写自取）

一寸免冠证件照片用于证书，请使用与网报照片同样底稿照片粘贴

**照片粘贴、证书邮寄信息**

姓名：\_\_\_\_\_\_\_\_\_\_\_\_ 网报号：\_\_\_\_\_\_\_\_\_\_\_\_

身份证号：\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

联系电话：\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

证书邮寄地址： （请与系统填报时保持一致，如该区域未开通邮寄或申请人不希望邮寄证书，此处填写自取）

附件2

江西省教师资格申请人员

体

检

表

|  |  |
| --- | --- |
| 江 西 省 教 育 厅 | 制 |

体 检 须 知

为了准确反映受检者身体的真实状况，请注意以下事项：

1.均应到指定医院进行体检，其它医疗单位的检查结果一律无效。

2.严禁弄虚作假、冒名顶替；如隐瞒病史影响体检结果的，后果自负。

3.体检表上粘贴近期正面一寸免冠彩色白底照片一张。

4.本表第一页由受检者本人填写（用黑色签字笔或钢笔），要求字迹清楚，无涂改，病史部分要如实、逐项填齐，不能遗漏。

5.体检前一天请注意休息，勿熬夜，不要饮酒，避免剧烈运动。

6.体检当天需进行采血、B超等检查，请在受检前禁食8-12小时。

7.女性受检者月经期间请勿做妇科及尿液检查，待经期完毕后再补检；怀孕或可能已受孕者，事先告知医护人员，勿做X光检查。

8.请配合医生认真检查所有项目，勿漏检。若自动放弃某一检查项目，将会影响对您的教师资格认定。

9.体检医师可根据实际需要，增加必要的相应检查、检验项目。

10.如对体检结果有疑义，请按有关规定办理。

江西省教师资格申请人员体检表

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 姓 名 |  | | | | | | | | 性 别 | | | |  | | | | | | 出生年月 | | | |  | | | | | | 照  片 | |
| 民 族 |  | | | | | | | | 婚姻状况 | | | |  | | | | | | 籍 贯 | | | |  | | | | | |
| 联系电话 |  | | | | | | | | 通讯地址 | | | |  | | | | | | | | | | | | | | | |
| 申请资格  种类 |  | | | | | | | | 身份证号 | | | |  | | | | | | | | | | | | | | | |
| 请本人如实详细填写下列项目  （在每一项后的空格中打“√”回答“有”或“无”，如故意隐瞒，责任自负） | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 病名 | | | | 有 | | 无 | | | | | | 治愈时间 | | | 病 名 | | | | | | | 有 | | | | | 无 | | 治愈时间 | |
| 高血压病 | | | |  | |  | | | | | |  | | | 糖尿病 | | | | | | |  | | | | |  | |  | |
| 冠心病 | | | |  | |  | | | | | |  | | | 甲亢 | | | | | | |  | | | | |  | |  | |
| 风心病 | | | |  | |  | | | | | |  | | | 贫血 | | | | | | |  | | | | |  | |  | |
| 先心病 | | | |  | |  | | | | | |  | | | 癫痫 | | | | | | |  | | | | |  | |  | |
| 心肌病 | | | |  | |  | | | | | |  | | | 精神病 | | | | | | |  | | | | |  | |  | |
| 支气管扩张 | | | |  | |  | | | | | |  | | | 神经官能症 | | | | | | |  | | | | |  | |  | |
| 支气管哮喘 | | | |  | |  | | | | | |  | | | 吸毒史 | | | | | | |  | | | | |  | |  | |
| 肺气肿 | | | |  | |  | | | | | |  | | | 急慢性肝炎 | | | | | | |  | | | | |  | |  | |
| 消化性溃疡 | | | |  | |  | | | | | |  | | | 结核病 | | | | | | |  | | | | |  | |  | |
| 肝硬化 | | | |  | |  | | | | | |  | | | 性传播疾病 | | | | | | |  | | | | |  | |  | |
| 胰腺疾病 | | | |  | |  | | | | | |  | | | 恶性肿瘤 | | | | | | |  | | | | |  | |  | |
| 急慢性肾炎 | | | |  | |  | | | | | |  | | | 手术史 | | | | | | |  | | | | |  | |  | |
| 肾功能不全 | | | |  | |  | | | | | |  | | | 严重外伤史 | | | | | | |  | | | | |  | |  | |
| 结缔组织病 | | | |  | |  | | | | | |  | | | 其他 | | | | | | |  | | | | |  | |  | |
| 备 注： | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 受检者签字：    体检日期： 年 月 日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 身高 | | 厘米 | | | | | | | | | 体重 | | | 公斤 | | | | | | | 血压 | | | | | / mmHg | | | | |
| 内  科 | | 病史：曾患过何种疾病（起病时间及目前症状）。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 心脏 | | | | | 心界  杂音 | | | | | | | | | | | 心率 | | | | | | | 次/分 律 | | | | | |
| 肺 | | | | |  | | | | | | | | | | | 腹部 | | | | | | |  | | | | | |
| 肝 | | | | |  | | | | | | | | | | | 神经系统 | | | | | | |  | | | | | |
| 脾 | | | | |  | | | | | | | | | | | 其他 | | | | | | |  | | | | | |
| 建议 | | | | |  | | | | | | | | | | | | | | | | | | 医师签字 | | | | |  |
| 外  科 | | 病史：曾做过何种手术或有无外伤史（名称及时间），目前功能如何。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 皮肤 | | | | |  | | | | | | | | | | | 浅表  淋巴结 | | | | | | |  | | | | | |
| 头颅 | | | | |  | | | | | | | | | | | 甲状腺 | | | | | | |  | | | | | |
| 乳腺 | | | | |  | | | | | | | | | | | 脊柱  四肢关节 | | | | | | |  | | | | | |
| 肛门  外生殖器 | | | | |  | | | | | | | | | | | 其他 | | | | | | |  | | | | | |
| 建议 | | | | |  | | | | | | | | | | | | | | | | | | 医师签字 | | | | |  |
| 眼  科 | | 裸眼  视力 | | | | | 右 | | | | | | | 矫 正  视 力 | | | 右 | | | | | | | | 医师签字 | | | | |  |
| 左 | | | | | | | 左 | | | | | | | |
| 色觉 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| 其他 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| 建议 | | | | |  | | | | | | | | | | | | | | | | | | 医师签字 | | | | |  |
| 耳  鼻  喉  科 | | 听力 | | | | | 左耳  右耳 | | | | | | | | | | | | | | | | | | 耳部 | | | | |  |
| 鼻部 | | | | |  | | | | | | | | | | | | | | | | | | 咽部 | | | | |  |
| 喉部 | | | | |  | | | | | | | | | | | | | | | | | | 嗅觉 | | | | |  |
| 其他 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| 建议 | | | | |  | | | | | | | | | | | | | | | | | | 医师签字 | | | | |  |
| 口  腔  科 | | | 唇腭舌 | | | | |  | | | | | | | | 牙齿 | | | | | | | |  | | | | | | | |
| 是否  口吃 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| 其他 | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| 建议 | | | | |  | | | | | | | | | | | | 医师签字 | | | | | | | |  | | | |
| 妇科检查 | | |  | | | | | | | | | | | | | | | | | 医师签字 | | | | | | | |  | | | |
| 心电图 | | |  | | | | | | | | | | | | | | | | | 医师签字 | | | | | | | |  | | | |
| 胸部X光片 | | |  | | | | | | | | | | | | | | | | | 医师签字 | | | | | | | |  | | | |
| 腹部B超  检查 | | |  | | | | | | | | | | | | | | | | | 医师签字 | | | | | | | |  | | | |
| 申请幼儿  教师资格  加测 | | | 妇科 | | 滴虫 | | | | |  | | | | | | | | | | 医师签字 | | | | | | | |  | | | |
| 念球菌 | | | | |  | | | | | | | | | |
| 注：对于滴虫和念球菌两项妇科检查项目未婚女性采取阴道口取样。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 体检结论  及建议 | | | 主检医师签字： 体检医院签章处  年 月 日 | | | | | | | | | | | | | | | | | | | | | | | | | | | | |