**广州医科大学附属妇女儿童医疗中心临床试验受试者费用签收表**

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| **项目名称** |  |

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| **申办方** | |  | | | | | | |
| **序号** | **受试者姓名** | **受试者/监护人领取信息（二选一）** | | | | **费用类型（补贴/检验检查费，注明访视期）** | **金额（元）** | **领取人签字/日期** |
| **姓名** | **银行卡号** | **身份证号** | **联系方式** |
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|  |  |  |  |  |  | **合计** |  |  |

**经办人/联系方式： 项目负责人：**

（一式两份：原件交财务，复印件存研究者文件夹）