附件３：

河南省红十字基金会贫困肿瘤患者救助对象汇总表

填写单位（盖章）： 　　　　　　时间： 年 月 日

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| 序号 | 姓名 | 性别 | 年龄 | 籍贯 | 疾病 | 身份证号 | 联系电话 | 申请时间 | 备注 |
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| 说明 | | 此表由省辖市红十字会每月填写汇总后报省红十字基金会。 | | | | | | | |