



Control No. \_\_\_\_\_

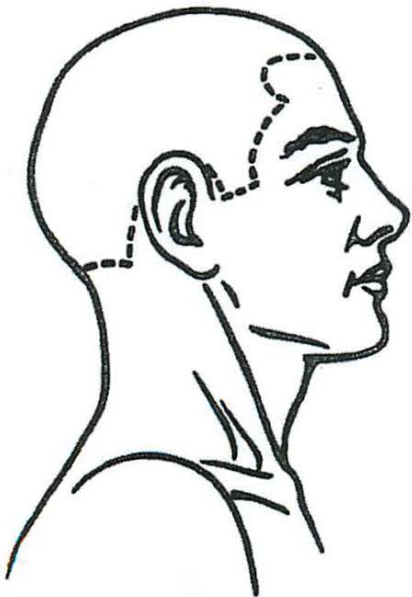
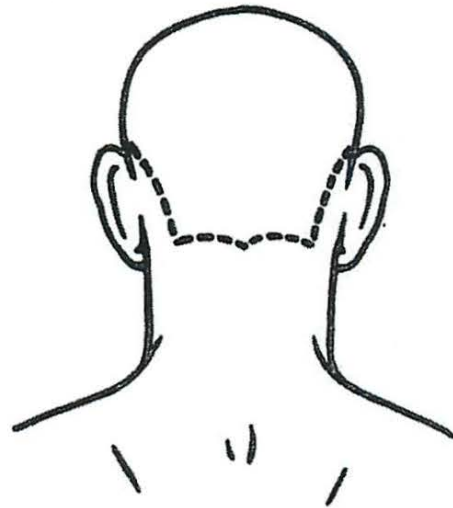
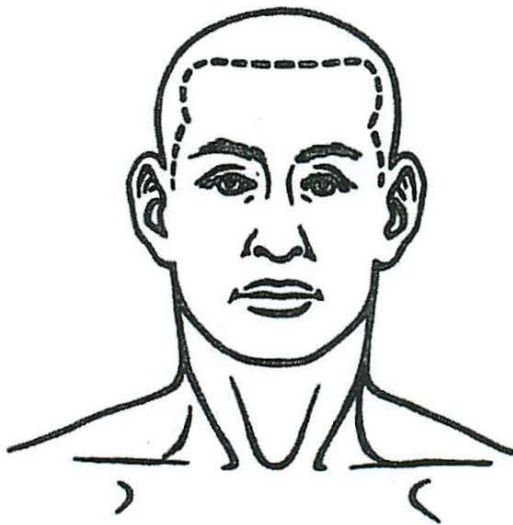
ML No. \_\_\_\_\_

Date: \_\_\_\_\_

Last name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Sex:  Male.  Female Age: \_\_\_\_\_

Date of examination: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.



\_\_\_\_\_  
Name and Signature of Examining physician