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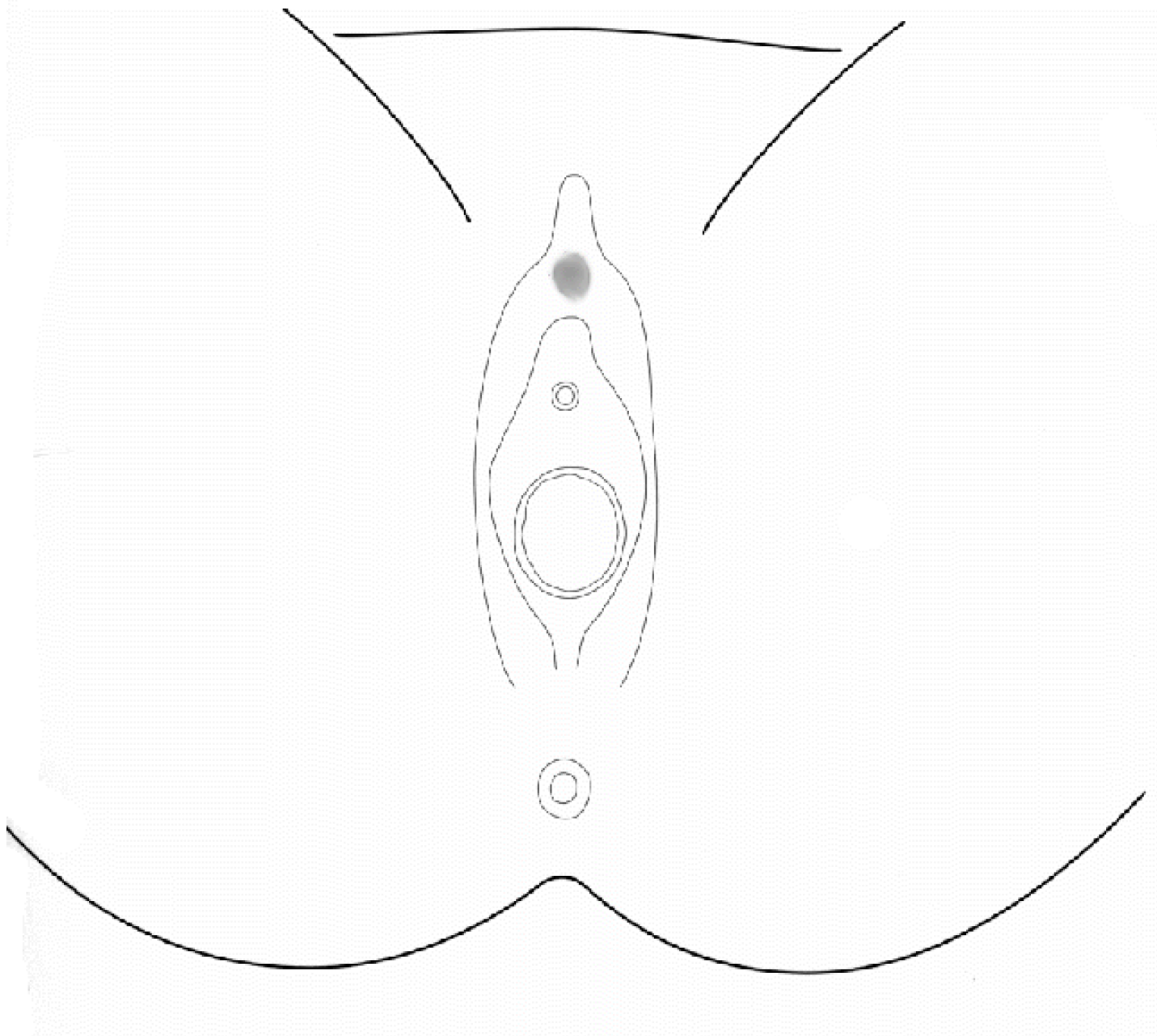
ML No. _____

Date: _____

Last name: _____ First Name: _____ Middle Name: _____

Sex: Male. Female Age: _____

Date of examination: _____ A.M. _____ P.M.



Name and Signature of Examining physician