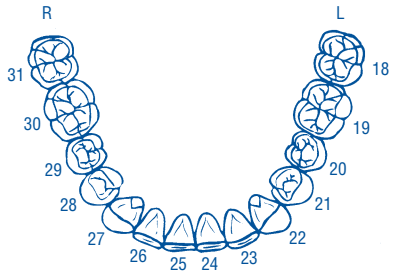
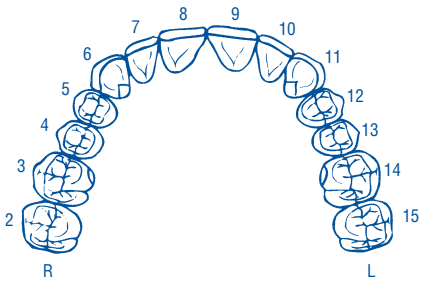


Dr. _____ Date _____

Patient _____

Shade	Mould	Age	Sex	Try-in	Finish	Due date



Signature

License #