CUI (when filled in)

REPORT OF TREATMENT FURNISHED PAY PATIENTS OUTPATIENT TREATMENT FURNISHED (PART B)						
1. INSTALLATION PROVIDING TREATMENT (Name and addre	2. MONTH AND YEAR COVERED BY THIS REPORT					
3. CATEGORY OF PATIENTS			4. AUTHORITY FOR ADMISSION			
NAME (Lead First middle initial) AND CON	MILITARY	ODOANIZATION	DIAGNOSIS		TREATMENT	
NAME (Last, first, middle initial) AND SSN 5	GRADE 6	ORGANIZATION 7	8 8		DATES 9	NUMBER 10
11. DATE 12. AUTHENTICATION (Signature, military grade, organization of Commanding Officer)					13. TOTAL	

DD FORM 7A, AUG 76

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