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

DD Form 7A, AUG 76 (EG)

S/N 0102-LF-000-0075