



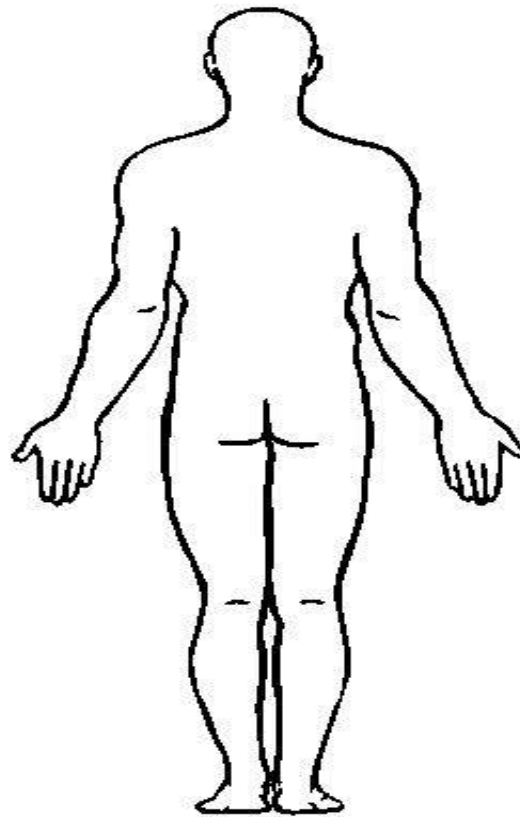
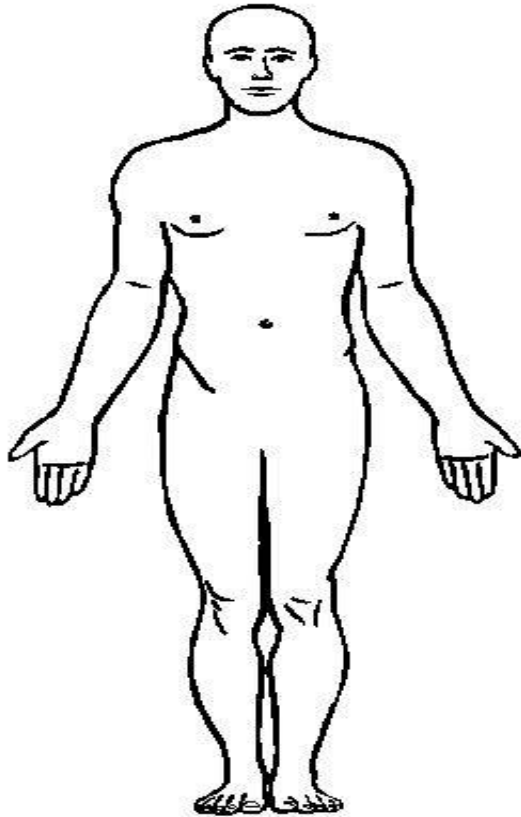
**Division of Criminal  
Justice Services**

Patient Name: \_\_\_\_\_

Examining Practitioner: \_\_\_\_\_

Date of Examination: \_\_\_\_\_

Healthcare Facility: \_\_\_\_\_



Distribution: Original in patient medical record; Copy in Part A Kit box