

**REPORT OF TREATMENT FURNISHED PAY PATIENTS
HOSPITALIZATION FURNISHED (PART A)**

REPORT CONTROL SYMBOL

1. INSTALLATION PROVIDING HOSPITALIZATION *(Name and address)*

2. MONTH AND YEAR COVERED BY THIS REPORT

3. CATEGORY OF PATIENTS

4. AUTHORITY FOR ADMISSION

NAME <i>(Last, first, middle initial)</i> AND SSN 5	MILITARY GRADE 6	ORGANIZATION 7	DIAGNOSIS 8	DATES		
				ADMISSION 9	DISCHARGE 10	TOTAL 11

12. DATE

13. AUTHENTICATION *(Signature, military grade, organization of Commanding Officer)*

14. TOTAL DAYS HOSPITALIZED