**DEPARTMENT OF THE ARMY**
**U.S. ARMY MEDICAL DEPARTMENT ACTIVITY**
**FORT CARSON, COLORADO 80913-5101**

REPLY TO
ATTENTION OF

HSXE-L (40a)

Date_____

To whom it may concern:

Patient: _____

Sponsor Name/Rank: _____

Social Security Number: _____

The above patient has been authorized to have a Sweat Chloride Test performed at government expense.

Please bill Evans Army Community Hospital, Department of Pathology, Fort Carson, Colorado 80913 for the cost of the test.

_____
Requesting/Authorizing Physician
Craig R. Webb, M.D.

Prepare in duplicate:

1. Original to civilian laboratory
2. Copy for Department of Pathology files