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

1. INSTALLATION PROVIDING HOSPITALIZATION *(Name and address)*	2. MONTH AND YEAR COVERED BY THIS REPORT *(YYYYMM)*

3. CATEGORY OF PATIENTS	4. AUTHORITY FOR ADMISSION

NAME *(Last, First, Middle Initial)* AND SSN 5	MILITARY GRADE 6	ORGANIZATION 7	DIAGNOSIS 8	DATES		
				ADMISSION 9	DISCHARGE 10	TOTAL 11

12. DATE	13. SIGNATURE	14. TOTAL DAYS HOSPITALIZED