

ORIGINAL

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to: **030672**

Florida Hospital Medical Center
601 East Rollins Street
Orlando FL 32803-1273

2. Article Number

(Transfer from service label)

7002 0860 0001 1755 6958

PS Form 3811, March 2001

Domestic Return Receipt

102595-01-M-1424

COMPLETE THIS SECTION ON DELIVERY

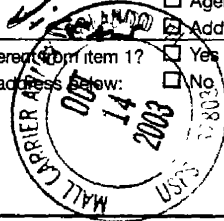
A. Receiver's Name (Please Print Clearly) B. Date of Delivery

C. Signature

X *E. Proia* Agent Addressee

D. Is delivery address different from item 1? Yes No

If YES, enter delivery address below:



3. Service Type

- Certified Mail Express Mail
- Registered Return Receipt for Merchandise
- Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

- AUS _____
- CAF _____
- CMP _____
- COM _____
- CTR _____
- ECR _____
- GCL _____
- OPC _____
- MMS _____
- SEC **+** _____
- OTH _____

DOCUMENT NUMBER-DATE

10165 OCT 17 8

FPSC-01-10-01-01-01