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| DATE: |  |  | TREATMENT CENTRE: |  |

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| **CLINICAL BOX NUMBER** | **ISSUED TO (Clinician’s name)** | **HOST NAME** | **TIME HANDED OUT** | **TIME SIGNED BACK IN** | **Sats machine present (please initial)** | **Thermometer present (please initial)** | **Ottoscope / Opthalmoscope present (please initial)** | **Stethoscope present (please initial)** |
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