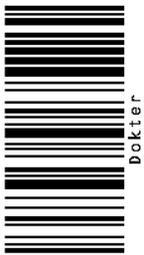
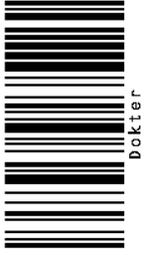


| | |
|------------------------------|---|
| | DOCTEUR |
| |  |
| PATIENT | |
| | |
| | |
| CACHET | DATE |
| SIGNATURE | |
| PRESCRIPTION MEDICALE | |

| | |
|------------------------------|---|
| | DOCTEUR |
| |  |
| PATIENT | |
| | |
| | |
| CACHET | DATE |
| SIGNATURE | |
| PRESCRIPTION MEDICALE | |

| | |
|------------------------------|---|
| | DOCTEUR |
| |  |
| PATIENT | |
| | |
| | |
| CACHET | DATE |
| SIGNATURE | |
| PRESCRIPTION MEDICALE | |