

QUALITY ASSURANCE REPRESENTATIVE'S CORRESPONDENCE

For use of this form see MEDCOM Sup 1 to AR 40-657, the proponent agency is MCCS-HV

1 TO:	2 FROM: (Name, address, ZIP Code, and office telephone number)
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3. CONTRACT: (P.O., OR O.I. NUMBER)	4. ITEM
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5. PRIME CONTRACTOR: (NAME, ADDRESS AND ZIP CODE)	6. PLANT: (NAME, ADDRESS, AND ZIP CODE)
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7. SIGNATURE OF QAR		8. DATE
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