DENTAL LABORATORY WORK AUTHORIZATION

STATE OF OKLAHOMA

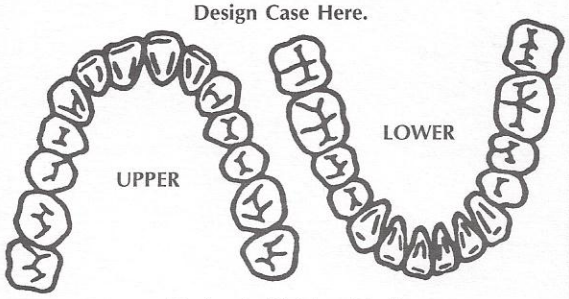
A000001

Date _____

Name of Laboratory _____

Address _____

Design Case Here.



Designate Right and Left

Patient _____

Type Restoration _____

_____

Shade _____

Mould _____

Material _____

_____

Date Wanted:

Try in _____

Finish _____

Please print or write legibly and make instructions as complete as possible. Use reverse side if necessary.

Signature _____ D.M.D. D.D.S.

Address _____

Dental License No. _____

MUST BE RETAINED BY DENTAL LABORATORY FOR 3 YEARS