Prescribed by State Board of Accounts. Form No. GH-10 (1950)

CHARGE SLIP-Out-Patient

No. _____

_____ Hospital

Dept. _____ Date _____ 19____

Patient _____

Address _____ Tele. No. _____

For the following services:

	AMOUNT	
	$	

FORWARD Original Copy to Bookkeeping Dept. Immediately.

Signed _____

Prescribed by State Board of Accounts. Form No. GH-10 (1950)

CHARGE SLIP-Out-Patient

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_____ Hospital

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