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)

3. CONTRACT: (P.O., OR O.I. NUMBER)	4. ITEM

5. PRIME CONTRACTOR: (NAME, ADDRESS AND ZIP CODE)	6. PLANT: (NAME, ADDRESS, AND ZIP CODE)

7. SIGNATURE OF QAR	8. DATE