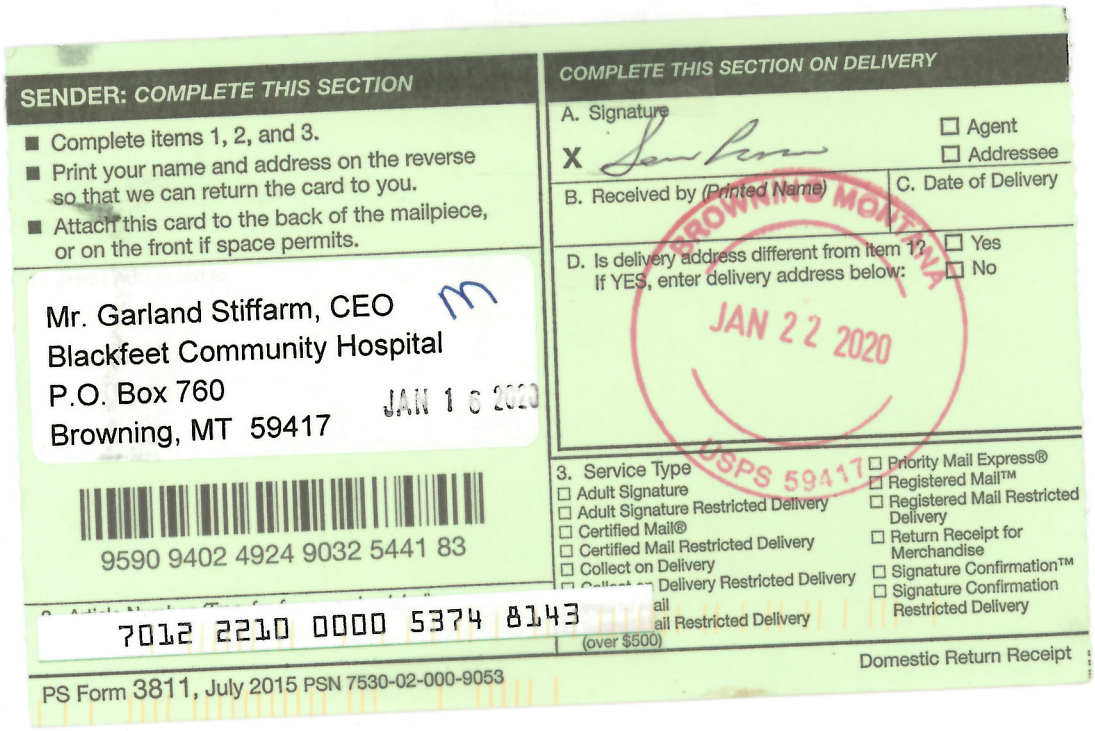

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

Mr. Garland Stiffarm, CEO
Blackfeet Community Hospital
P.O. Box 760
Browning, MT 59417

JAN 16 2020

9590 9402 4924 9032 5441 83

7012 2210 0000 5374 8143

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X
☐ Agent
☐ Addressee

B. Received by (Printed Name) | C. Date of Delivery

D. Is delivery address different from item 1?
If YES, enter delivery address below:
☐ Yes
☐ No

BROWNING MONTANA
JAN 22 2020
USPS 59417

3. Service Type
☐ Adult Signature
☐ Adult Signature Restricted Delivery
☐ Certified Mail®
☐ Certified Mail Restricted Delivery
☐ Collect on Delivery
☐ Collect on Delivery Restricted Delivery
☐ Priority Mail Express®
☐ Registered Mail™
☐ Registered Mail Restricted Delivery
☐ Return Receipt for Merchandise
☐ Signature Confirmation™
☐ Signature Confirmation Restricted Delivery
(over $500)

PS Form 3811, July 2015 PSN 7530-02-000-9053 Domestic Return Receipt

SDWA-08-2019-0021