

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> ■ 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. 	<p>A. Signature <input checked="" type="checkbox"/> <i>John M. Wissing</i> <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee</p>
<p>1. Article Addressed to: Mayo Clinic Health System c/o Gordie Howie 700 West Ave La Crosse, WI 54601</p>	<p>B. Received by (Printed Name) <i>John M. Wissing</i></p> <p>C. Date of Delivery <i>2-9-2020</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p>
 9590 9402 8728 3310 5307 41	<p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express® <input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™ <input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery <input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Signature Confirmation™ <input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery <input type="checkbox"/> Collect on Delivery Restricted Delivery <input type="checkbox"/> Insured Mail <input type="checkbox"/> Insured Mail Restricted Delivery (over \$500)</p>
<p>2. Article Number (Transfer from service label) 589 0710 5270 1994 4862 59</p>	
<p>PS Form 3811, July 2020 PSN 7530-02-000-9053 Domestic Return Receipt</p>	

U.S. Postal Service™ CERTIFIED MAIL® RECEIPT Domestic Mail Only	
For delivery information, visit our website at www.usps.com ®.	
<h1 style="color: lightblue; opacity: 0.5;">OFFICIAL USE</h1>	
<p>Certified Mail Fee \$ _____</p> <p>Extra Services & Fees (check box, add fee as appropriate)</p> <p><input type="checkbox"/> Return Receipt (hardcopy) \$ _____</p> <p><input type="checkbox"/> Return Receipt (electronic) \$ _____</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery \$ _____</p> <p><input type="checkbox"/> Adult Signature Required \$ _____</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery \$ _____</p> <p>Postage \$ _____</p> <p>Total Postage and Fees \$ _____</p>	<p style="text-align: right; color: blue;">REANNING</p> <div style="border: 2px solid red; border-radius: 50%; padding: 10px; text-align: center;"> <p>POSTMARK HERE JAN 30 2020 USPS</p> </div>
<p>Sent To <i>Mayo Clinic Health System c/o Gordie Howie</i></p> <p>Street and Apt. No., or PO Box No. <i>700 West Ave</i></p> <p>City, State, ZIP+4® <i>La Crosse, WI 54601</i></p>	
<p>PS Form 3800, January 2023 PSN 7530-02-000-9047 See Reverse for Instructions</p>	

9589 0710 5270 1994 4862 59