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.

1. Article Addressed to:

Mayo Clinic Health System
c/o Gordie Howie
700 West Ave
La Crosse, WI 54601

9590 9402 8728 3310 5307 41

2. Article Number (Transfer from service label)

5589 0710 5270 1994 4862 59

COMPLETE THIS SECTION ON DELIVERY

A. Signature

X [signature] ☑ Agent ☐ Addressee

B. Received by (Printed Name) John M Wissing

C. Date of Delivery 2-9-2026

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

3. Service Type

- ☐ Adult Signature
- ☐ Adult Signature Restricted Delivery
- ☑ Certified Mail®
- ☐ Certified Mail Restricted Delivery
- ☐ Collect on Delivery
- ☐ Collect on Delivery Restricted Delivery
- ☐ Insured Mail
- ☐ Insured Mail Restricted Delivery (over $500)
- ☐ Priority Mail Express®
- ☐ Registered Mail™
- ☐ Registered Mail Restricted Delivery
- ☐ Signature Confirmation™
- ☐ Signature Confirmation Restricted Delivery

PS Form 3811, July 2020 PSN 7530-02-000-9053 Domestic Return Receipt

5589 0710 5270 1994 4862 59

U.S. Postal Service™
CERTIFIED MAIL® RECEIPT
Domestic Mail Only

For delivery information, visit our website at www.usps.com®.

OFFICIAL USE

Certified Mail Fee
$

Extra Services & Fees (check box, add fee as appropriate)

- ☐ Return Receipt (hardcopy) $
- ☐ Return Receipt (electronic) $
- ☐ Certified Mail Restricted Delivery $
- ☐ Adult Signature Required $
- ☐ Adult Signature Restricted Delivery $

Postage
$

Total Postage and Fees
$

PLANNING

Postmark Here
JAN 30 2026

Sent To
Mayo Clinic Health System c/o Gordie Howie
Street and Apt. No., or PO Box No.
700 West Ave
City, State, ZIP+4®
La Crosse, WI 54601

PS Form 3800, January 2023 PSN 7530-02-000-9047 See Reverse for Instructions