

**FOOD AND DRUG ADMINISTRATION (FDA)  
RECALLS/ALERT NOTICES**

1. **FDA MEDICAL EQUIPMENT RECALLS AND ALERTS.** The following recalls are reported in accordance with AFMLL 2-95, page CE-4, and should be treated as directed modifications in accordance with that AFMLL and AFI 41-201, Chapter 2, Section D. If you possess any of these items and have not received recall notification, you should contact the manufacturer for recall instructions. Suspension is only required for Class I items. (FOM, Capt David Zemkosky, DSN 343-4028)

**CLASS I RECALLS:** None

**CLASS II RECALLS:**

6515NS  
MDC 18076  
PRODUCT Oxygen Delivery Unit, Controlled  
Lifesaver Portable Oxygen Units, Catalog No. 5000, indicated for delivery of approximate low, medium and high concentrations of oxygen. Recall #Z-017-7.

CODE Serial numbers:  
MHG9411                   MHG9412                   MHG9502                   MHG9505  
-0006                   -0017                   -0014                   -0002  
-0009                   -0018                   -0016                   -0006  
-0011                   -0020                   -0017                   -0065  
-0053                   -0042                   -0027                   -0068  
-0054   -0028                   -0075  
-0055   -0029                   -0076  
-0057   -0030                   -0077  
-0059   -0078  
   -0096

MANUFACTURER           Hudson Respiratory Care, Inc., Temecula, California.  
RECALLED BY           Manufacturer, by telephone on June 14, 1996, followed by letter on June 18 and 19, 1996. Firm-initiated recall ongoing.

DISTRIBUTION           California, Texas, Illinois, Pennsylvania, Utah, Missouri, Massachusetts, Canada, Honduras.

QUANTITY               42 units were distributed.

REASON                 Device was distributed with a regulator with a flow range of 1-8 LPM, instead of the correct regulator with af low range of 2-15 LPM.

[ ] None Present  
[ ] Action Taken \_\_\_\_\_

6515NS  
MDC 12873  
UPDATE Oxygen Concentrators  
Invacare Oxygen Concentrators Mobilaire III/V, and Invacare III/V Oxygentrators, Recall #Z-1216/1219-6, which appeared in AFMLL 22-96, Attachment 2, should read as follows:

PRODUCT (a) Mobilaire III Oxygen Concentrator, Model No. IRC301;  
(b) Mobilaire V Oxygen Concentrator, Model No. IRC501;  
(c) Invacare V Oxygen Concentrator, Model No. IRC 50102, with optional oxygen, Purity Indictor. Recall #Z-1216/1218-6.

CODE Serial Numbers 96B46257-94B46706, 96B99247-96B99265 and 96B50320-96B50916 which corresponds to all of the involved devices manufacturer from 1/30/96 to 2/27-96.

MANUFACTURER Invacare Corporation, Sanford, Florida.

RECALLED BY Manufacturer, by telephone on March 8, 1996, and October 4, 1996. Firm-initiated recall ongoing.

DISTRIBUTION Nationwide.

QUANTITY 193 units were distributed.

REASON Kinked oxygen transfer hoses in the units caused by defective exterior foam insulation may affect the flow of oxygen, and therefore, affect the concentration of oxygen the patient receives.

None Present  
 Action Taken \_\_\_\_\_

CLASS III RECALLS: None

MEDICAL EQUIPMENT SAFETY ALERTS: None

**2. DRUG/SUPPLY PRODUCT RECALLS AND MEDICAL INFORMATION.** The Food and Drug Administration (FDA) advises that the drug products listed below were recalled by the manufacturers or distributors concerned. The FDA has classified these recalls as follows:

**CLASS I:** A situation in which there is a reasonable probability that the use of, or exposure to, a violative product will cause serious, adverse health consequences or death.

**CLASS II:** A situation in which the use of, or exposure to, a violative product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.

**CLASS III:** A situation in which the use of, or exposure to, a violative product is not likely to cause adverse health consequences.

Most of these items are nonstandard, and the possibility exists that medical activities may have purchased them locally. There is also a possibility that some of these items have NSNs assigned and may have been reported in earlier Q.A. messages. Activities having quantities of [AU]these items on hand will immediately suspend the materiel from issue and use. CONUS activities will contact the nearest office of the respective manufacturer or distributor for disposition instructions. OVERSEAS activities will report quantities suspended to AFMLO/FOCO no later than 20 DEC 96 for disposition instructions. They should include nomenclature; lot number; manufacturer; quantity suspended; strength size; requisition; and DPSC purchase order number, contract number, and stock record account number (SRAN).  
(FOM-P), Bonnie Phillips, DSN (343-7445)

CLASS I RECALLS:

NSN 6505 Nonstandard  
UPDATE Recall #D-254-6, Adrenal Cortex Injection, which appeared in the October 16, 1996 Enforcement Report, should read as follows: SEE AFMLL 23-96.

PRODUCT All sizes and strengths of ADRENAL CORTEX INJECTION, a Rx injectable drug, labeled as distributed by Hallmark Labs, Chicago, IL. Recall #D-254-6.

CODE All codes (most units are uncoded).  
MANUFACTURER (primary) Ontor Beauty Products, Inc., Opa Locka, Florida.

RECALLED BY Phyne Pharmaceuticals, Inc., Scottsdale, Arizona (own-label distributor); by letter mailed October 1, 1996. Firm-initiated; ongoing. See also FDA press release P96-13, August 30, 1996.

DISTRIBUTION Nationwide.  
QUANTITY Undetermined.  
REASON Mycobacterium abscessus contamination of unopened vial of Hallmark Labs' labeled product distributed by Phyne Pharmaceuticals and epidemiological data collected by CDC correlating the use of this product with Mycobacterium abscesses at the site of injection.

None Present  
 Action Taken \_\_\_\_\_  
\_\_\_\_\_

CLASS II RECALLS

NSN 6515 Nonstandard  
PRODUCT Max-I-Probe Endodontic Irrigation Syringe:  
(a) Catalog # MAXE125, 3cc syringe, 25G probe, 1-2% NaOCl solution  
(b) Catalog # MAXE625, 3cc syringe, 25G probe, 4-6% NaOCl solution  
(c) Catalog # MAXE628, 3cc syringe, 28G probe, 4-6% NaOCl solution  
(d) Catalog # MAXE630, 3cc syringe, 30G probe, 4-6% NaOCl solution  
(e) Catalog # MAXE650, trial kit of 2 trays--

1 tray of 3cc syringes and 1 tray of 10cc syringes, with each tray containing 1- 25G, -28G and 2-30G probes, with 4-6% NaOCl solution

(f) Catalog # MAXE825, 3cc syringe, 25G probe, 2-3% NaOCl solution

(g) Catalog # MAXE828, 3cc syringe, 28G probe, 2-3% NaOCl solution

(h) Catalog # MAXE830, 3cc syringe, 30G probe, 2-3% NaOCl solution. Recall #Z-007/014-7.

CODE Lot numbers: (a) 96G13; (b) 96G01; (c) 96G03; (d) 96G05; (e) 96G001; (f) 96G07; (g) 96G09; (h) 96G11.

MANUFACTURER MPL Technologies, Inc., Franklin Park, Illinois.

RECALLED BY Manufacturer, by letter September 9, 1996. Firm-initiated recall ongoing.

DISTRIBUTION Nationwide and Belgium.

QUANTITY 12,455 syringes were distributed.

REASON The external finger grip flanges may separate from the barrel of the syringe, rendering the syringe inoperable.

[ ] None Present  
[ ] Action Taken \_\_\_\_\_

NSN 6515 Nonstandard  
PRODUCT Low Porosity Woven Vascular Prosthesis, Catalog #OLP1206, indicated for replacement or bypass procedures in aneurysmal and occlusive disease of the abdominal aorta, visceral arteries and proximal peripheral arteries exclusive of the coronary arteries. Recall #Z-019-7.

CODE	SERIAL NUMBERS	LOT NOS.
	3053001	94K18
	3053003	94K18
	3053007	94K18
	3053008	94K18
	3053009	94K18
	3095001	92K09
	3095002	92K09
	3095003	92K09
	3095004	92K09
	3095005	92K09
	3095006	92K09
	3095007	92K09
	3095008	92K09
	3095010	92K09

	3100603	92J18
	3100604	92J18
	3100608	92J18
	3210201	92K02
	3210203	92K02
	3210204	92K02
	3210205	92K02
	3210206	92K02
	3210207	92K02
	3210208	92K02
	3210209	92K02
	3285301	93E21
	3285302	93E21
	3285304	93E21
	3285306	93E21
	3285307	93E21
	3285308	93E21
	3286301	93C26
	3286302	96E17
	3286303	96E17
	3286304	93C26
	3286307	93C26
	3286309	93C26
	3414701	93E21
	3414702	93E21
	3414703	93E21
	3414706	93E21
	3414709	93E21
	3436101	93F30
	3436404	93F30
	3436409	96E17
	3436410	96A10
	3458903	96E17
	3458906	93D30
	3458907	93D30
	3529702-3529708	95K13
	3550001-3550004	94M16
	3551001-3551010	95M01.
MANUFACTURER	Intervascular Inc., Clearwater, Florida.	
RECALLED BY	Manufacturer, by telephone on August 21, 1996, followed by letter. Firm-initiated recall complete.	
DISTRIBUTION	Tennessee, New York, Louisiana, Illinois, Alabama, Florida, California, Pennsylvania, Arizona, Georgia, Texas, New Jersey, Ohio, Japan.	
QUANTITY	65 unimplanted devices were in commerce at time of recall initiation.	
REASON	One thread is missing in the involved woven vascular prosthesis which may potentially increase water permeability along the line of	

the pulled thread.

[ ] None Present  
[ ] Action Taken \_\_\_\_\_

NSN  
PRODUCT

6515 Nonstandard

Input PS Catheter Introducer Sheath with Hydro/pel Coating, used to facilitate placing a catheter through the skin into a vein or artery:

(a) 5F

1000511	5F 11 CM Input 2 (Freeway)
050011	5F 11 cm Input Introducer Intl.
055011	5F 11 cm Input Introducer
063311	5F 11 cm Input II Introducer
553311	5F 11 cm Input Introducer Intl
853311	5F 11 cm Input Introducer
FC4631951	5F Grey Input II Assembly

(b) 6F

1000611	6F 11 cm Input 2 (Freeway)
060011	6F 11 cm Input Introducer Intl.
063312	6F 11 cm Input II Introducer
065011	6F 11 cm Input Introducers
563311	6F 11 cm Input Introducer Intl.
863311	6F 11 cm Input Introducer
1000623	6F 23 cm Input 2 (Freeway)
060023	6F 23 cm Input Introducer kit.
063317	6F 23 cm Input II Introducer kit
FC4631952	6F Green Input II Assembly

(c) 7F

1000711	7F 11 cm Input 2 (Freeway)
063313	7F 11 cm Input II Introducer
070011	7F 11 cm Input Introducer Intl.
075011	7F 11 cm Input Introducer
573311	7F 11 cm Input Introducer Intl.
873311	7F 11 cm Input Introducer
1000723	7F 23 cm Input 2 (Freeway)
063318	7F 23 cm Input 2 Introd. Kit
070023	7F 23 cm Input Introducer Kit
FC4631953	7F Orange Input II Assembly

(d) 8F

080011	8F 11 cm Input Introducer Intl.
085011	8F 11 cm Input Introducers
080023	8F 23 cm Input 2 (Freeway)
583311	8F 11 cm Input Introducers Intl.
883311	8F 11 cm Input Introducer
063314	8F 11 cm Input II Introducer
063319	8F 11 cm Input II Introducer kit
1000823	8F 23 cm Input 2 (Freeway)

1000811 8F 11 cm Input 2 (Freeway)  
 FC4631954 8F Blue Input II Assembly  
 (e) 9F  
 063320 9F 23 cm Input 2 Introducer Kit  
 090023 9F 23 cm Input Introducer Kit  
 063315 9F 11 cm Input II Introducer  
 090011 9F 11 cm Input Introducer Intl.  
 095011 9F 11 cm Input Introducers  
 593311 9F 11 cm Input Introducer Intl.  
 893311 9F 11 cm Input Introducer  
 FC4631955 9F Grey Input II Assembly.  
 Recall #Z-020-024-7.

CODE All lot numbers of product produced since May 1995.

MANUFACTURER C.R. Bard Irl., Ballybrit, Galway.

RECALLED BY USCI Manufacturing Facility, Billerica, Massachusetts, by letter on August 13, 1996, and by telephone and interoffice mail. Firm-initiated recall ongoing.

DISTRIBUTION Nationwide and international.

QUANTITY Approximately 980,539 units were distributed.

REASON Introducer hub is separating at or near the weld site of the upper and lower hub body parts. Failure could result in significant blood loss or air embolism.

[ ] None Present  
 [ ] Action Taken \_\_\_\_\_

NSN 6515 Nonstandard

PRODUCT Lifesaver Portable Oxygen Units, Catalog No. 5000, indicated for delivery of approximate low, medium and high concentrations of oxygen. Recall #Z-017-7.

CODE Serial numbers:

MHG9411	MHG9412	MHG9502	MHG9505
-0006	-0017	-0014	-0002
-0009	-0018	-0016	-0006
-0011	-0020	-0017	-0065
-0053	-0042	-0027	-0068
-0054		-0028	-0075
-0055		-0029	-0076
-0057		-0030	-0077
-0059			-0078
			-0096.

MANUFACTURER Hudson Respiratory Care, Inc., Temecula, California.

RECALLED BY Manufacturer, by telephone on June 14, 1996, followed by letter on June 18 and 19, 1996. Firm-initiated recall ongoing.

DISTRIBUTION California, Texas, Illinois, Pennsylvania, Utah, Missouri, Massachusetts, Canada, Honduras.

QUANTITY 42 units were distributed.

REASON

Device was distributed with a regulator with a flow range of 1-8 LPM, instead of the correct regulator with a flow range of 2-15 LPM.

- [ ] None Present
- [ ] Action Taken \_\_\_\_\_

NSN

6525 Nonstandard

PRODUCT

Microvision-C Radiographic Film, used for mammography. Recall #Z-027/028-7.

CODE

Product is identified by Type, Emulsion #, Run #, and Cut#:

GROUP A

TYPE	EMULSION	RUN	CUT	SIZE	STOCK#
597	6042	0038	ALL	18X24	529567
		0050	ALL	18X24	529567
		0054	ALL	18X24	529567
597	6052	0034	ALL	18X24	529567
		0035	ALL	18X24	529567
		0075	ALL	18X24	529567
597	6062	0034	ALL	24X30	52963A
		0035	ALL	18X24	529567
		0035	01-07 21-26	24X30	52963A
		0036	03-07	18X24	529567
		0036	01,02	24X30	52963A
		0037	ALL	18X24	529567
		0048	ALL	24X30	52963A
		0069	03-07	18X24	529567
		0069	01,02	24X30	52963A
		0078	ALL	18X24	529567

(b) GROUP B

TYPE	EMULSION	RUN	CUT	SIZE	STOCK#
597	6052	0036	ALL	18X24	529567
597	6062	0027	03-07	18X24	529567
		0027	01,02	24X30	52963A
		0032	ALL	18X24	529567
		0051	ALL	24X30	52963A
		0059	ALL	18X24	529567
		0068	03-07	18X24	529567
		0068	01,02	24X30	52963A
		0070	ALL	24X30	52963A
		0071	03-07	18X24	529567
		0071	01,02	24X30	52063A
		0072	03-07 21-26	18X24	529567
		0072	01,02	24X30	52963A
		0073	03,07	18X24	529567
		0073	01,02	24X30	52963A
		0076	ALL	24X30	52963A
		0077	03-07	18X24	529567
		0077	01,02	24X30	52963A

597 6072 0046 ALL 24X30 52963A  
0049 ALL 24X30 52963A.

MANUFACTURER Sterling Diagnostic Imaging, Inc., Brevard,  
North Carolina.

RECALLED BY Sterling Diagnostic Imaging, Inc., Newark,  
Delaware, by letter dated August 30, 1996.  
Firm-initiated recall ongoing.

DISTRIBUTION Nationwide, Mexico, Brazil, Latin America.

QUANTITY Firm estimated that 19,388 boxes of film  
remained on market at time of recall  
initiation.

REASON The devices have demonstrated uncharacteristic  
aging, that is below working limits for speed  
for this product, which may result in the  
mis-diagnosis in mammography readings.

[ ] None Present  
[ ] Action Taken \_\_\_\_\_

CLASS III RECALLS

NSN 6505 Nonstandard

PRODUCT Merck's Aquamephyton (Vitamin K) for  
Injection, 10 mg/ml, in 2.5 ml and 5 ml vials,  
indicated for use in the treatment of  
prophylaxis and treatment of hemorrhagic  
disease of the newborn; anticoagulant-induced  
prothrombin deficiency in adults;  
hypoprothrombinemia due to other causes in  
adults. Recall #D-006-7.

CODE Lot numbers: 1255A EXP 12/31/96, 0208B EXP  
2/28/97, 0226B EXP 5/31/97.

MANUFACTURER Merck Manufacturing Division, Division of  
Merck and Company, Inc., West Point,  
Pennsylvania.

RECALLED BY Manufacturer, by letter on October 10, 1996.  
Firm-initiated recall ongoing.

DISTRIBUTION Nationwide.

QUANTITY Firm estimates that 10,000 market packages  
remained on market at time of recall  
initiation.

REASON Product may be subpotent due to the stopper  
absorbing the active ingredient.

[ ] None Present  
[ ] Action Taken \_\_\_\_\_

URGENT DRUG RECALLS/ADDITIONAL INFORMATION:

NSN: 6505-00-153-8278  
PRODUCT: IMMUNE GLOBULIN  
MANUFACTURER: ARMOUR/CENTEON  
LOT NUMBERS: ALL LOTS  
REFERENCE Q. A. MESSAGES 5075-0011 AND 6185-0015. ARMOUR  
PHARMACEUTICAL DIVISION OF CENTEON HAS RECALLED ALL! REPEAT ALL!  
IMMUNE GLOBULIN (IG) INTRAMUSCULAR INJECTION,  
NSN, 6505-00-153-8278. ENSURE ALL LOTS HAVE BEEN SUSPENDED FROM  
ISSUE AND USE. RETURN ALL MATERIEL TO THE FOLLOWING:

RHONE-POULENC RORER (RPR)  
DISTRIBUTION CTR  
ATTN: RETURN GOODS PROCESSING  
18504 WEST CREEK DRIVE  
TINLEY PARK, IL 60477 USA

EMERGENCY REQUESTS FOR IG SHOULD BE PLACED THROUGH AFMLO,  
PROVIDING PATIENT'S NAME AND BRIEF NARRATIVE SUMMARIZING THE  
REASON FOR THE REQUEST.  
ALL ACTIVITIES SHOULD PROCESS AN ESU TRANSACTION (WHETHER YOU  
HAVE A MASTER RECORD OR NOT) TO ESTABLISH A SUSPENDED ITEM FILE.  
ENSURE THE Q. A. MESSAGE NUMBER IS LOADED IN THE AUTHORITY  
FIELD.  
THIS CONFIRMS Q.A. MESSAGE 6299-0029.

[ ] None Present  
[ ] Action Taken \_\_\_\_\_  
\_\_\_\_\_

NSN: 6505-01-213-9514  
PRODUCT: GENTAMICIN SULFATE INJECTION USP, 40 MG/ML,  
2 ML,CAT 01402  
NDC NUMBER: 39769-014-02  
LOT NUMBER: 951150

NSN: 6505-01-088-3692  
PRODUCT: GENTAMICIN SULFATE INJECTION USP, 40 MG/ML,  
20 ML,CAT 01420  
NDC NUMBER: 39769-014-20  
LOT NUMBER: 950957  
REASON: THERE IS A POTENTIAL PRESENCE OF ENDOTOXIN  
IN THE ABOVE LOTS.

THE ABOVE MATERIEL MANUFACTURED BY SOLOPAK LABORATORIES INC., IS  
BEING RECALLED. THIS RECALL HAS BEEN REPORTED TO THE FOOD AND  
DRUG ADMINISTRATION.  
NSN 6505-01-213-9514, NDC NUMBER 39769-0014-02 MAY HAVE BEEN  
PURCHASED FROM DPSC AS DIRECT VENDOR DELIVERY. A RETURN GOODS  
AUTHORIZATION AND SHIPPING LABELS ARE REQUIRED. FOR RETURNED  
GOODS AUTHORIZATION NUMBER/FORM/SHIPPING LABELS, CONTACT SOLOPAK

LABORATORIES, INC., CUSTOMER SERVICE DEPARTMENT, PHONE 1-800-225-7626. FREIGHT CHARGES WILL BE REIMBURSED IF THEY ARE INDICATED ON A DEBIT MEMO OR ON THE PACKING SLIP ACCOMPANYING THE RETURNED PRODUCT.

THIS CONFIRMS Q.A. MESSAGE 6302-0030.

None Present  
 Action Taken \_\_\_\_\_

NSN: 6505-01-420-4959/6505-01-420-4960  
(PARKE-DAVIS ONLY)  
PRODUCT: FLUOGEN (INFLUENZA VIRUS VACCINE, TRIVALENT, TYPES A AND B)  
LOT NUMBERS: 00576P AND 00786P: SYRINGES, N 0071-4096-40  
LOT NUMBER: 00966P: VIALS, N 0071-4096-08  
REASON: BECAUSE OF DECREASED POTENCY OF THE A. NANCHANG 933/95 (H3N2) STRAIN. AT PRESENT, NO AVAILABLE DATA TO SUGGEST THAT THERE IS ANY BASIS FOR INDIVIDUALS ALREADY IMMUNIZED WITH THESE LOTS TO BE CONCERNED.

THE ABOVE MATERIEL MANUFACTURED BY PARKED-DAVIS, DIVISION OF WARNER-LAMBERT CO., IS BEING RECALLED IMMEDIATELY. THIS RECALL IS BEING CONDUCTED AS A PRECAUTIONARY MEASURE AND WITH THE FULL KNOWLEDGE OF THE FOOD AND DRUG ADMINISTRATION. THESE LOTS WOULD HAVE BEEN PURCHASED LOCALLY AND MANUFACTURED BY PARKE-DAVIS COMPANY AND DISTRIBUTED BETWEEN JULY AND SEPTEMBER 1996. PLEASE CHECK YOUR STOCK IMMEDIATELY. IF YOU HAVE ANY OF THE ABOVE LOTS ON HAND, PLEASE STOP USE AND PROMPTLY RETURN TO:

PARKE-DAVIS  
MUNSONHURST ROAD COMPLEX  
FRANKLIN, NJ 07416

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE MEDICAL AFFAIRS DEPARTMENT, PHONE 1-800-223-0432. REIMBURSEMENT FOR THE RETURNED

GOODS AND SHIPPING COST WILL BE MADE BY CREDIT MEMORANDUM OR CHECK.

THIS CONFIRMS Q.A. MESSAGE 6309-0031.

None Present  
 Action Taken \_\_\_\_\_

NSN: 6550-01-389-0237, 6550-01-293-5595  
PRODUCT: TEST STRIPS GLUCOSE PLASTIC AND PAPER MATERIEL 600S  
NDC NUMBER: F53885-0198-50  
MANUFACTURER: LIFESCAN  
LOT NUMBERS: 609816A

TRADE NAME: ONE TOUCH  
REASON: INCORRECT CALIBRATION CODE MAY OBTAIN INACCURATE  
HIGH RESULTS WHICH MAY PRESENT A HEALTH RISK,  
PARTICULARLY AT LOW GLUCOSE LEVELS.

THE ABOVE MATERIEL IS BEING RECALLED BY LIFESCAN , AND IS NOT  
DEPOT STOCK BUT COULD HAVE BEEN PROCURED LOCALLY. IF  
WHOLESALER/DISTRIBUTOR HAS NOTIFIED YOU COMPLY WITH THEIR  
INSTRUCTIONS. OTHERWISE, IF MATERIEL FOUND, CONTACT LIFESCAN,  
CUSTOMER SUPPORT, PHONE NUMBER: 1-800-951-7226 OR  
COML: (408) 263-9789 FOR RETURN GOODS INFORMATION CONCERNING  
CREDIT/REPLACEMENT AND FURTHER ASSISTANCE IF NEEDED. CONUS  
ACTIVITIES WILL ACKNOWLEDGE RECEIPT OF THIS MESSAGE  
TO AFMLO/FOM-P BY CALLING DSN: 343-4170 COML: 301-619-4170,  
E-MAIL TO: PHILLIB@FTDETRCK-CCMAIL.ARMY.MIL OR FAX: DSN: 343-  
2557, COML: 301-619-2557, WITHIN 2 WORKING DAYS AFTER THE DATE  
OF THIS MESSAGE. OVERSEAS ACTIVITIES WILL ACKNOWLEDGE RECEIPT OF  
THIS MESSAGE WITHIN 3 WORKING DAYS.

5. THIS INFORMATION WILL BE PUBLISHED IN THE AFMLL 24-96.  
THIS CONFIRMS Q. A. MESSAGE 6312-0032.

None Present  
 Action Taken \_\_\_\_\_  
\_\_\_\_\_