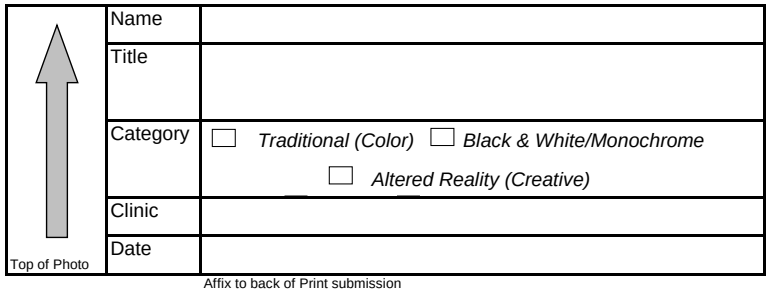
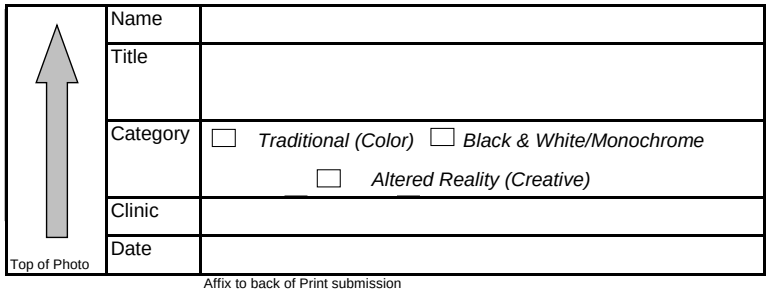


Name	
Title	
Category	☐ *Traditional (Color)* ☐ *Black & White/Monochrome* ☐ *Altered Reality (Creative)*
Clinic	
Date	

Top of Photo

Affix to back of Print submission

** If submitted to Alterated Reality, include description of process.*



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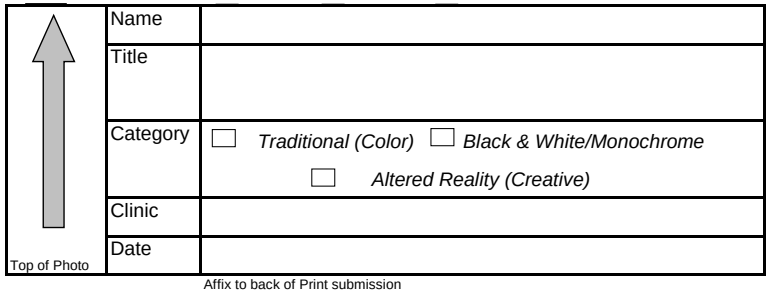

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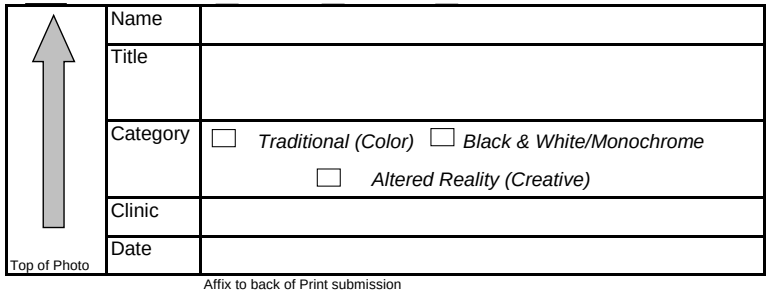

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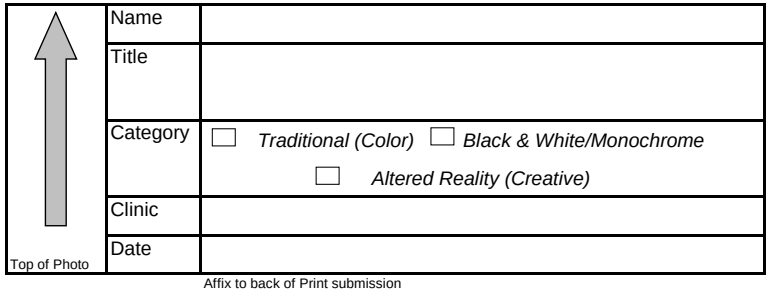

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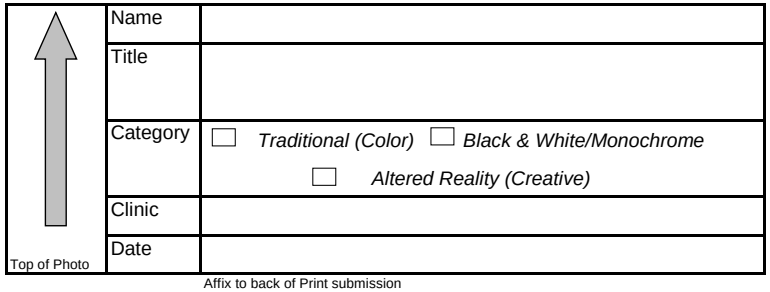

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