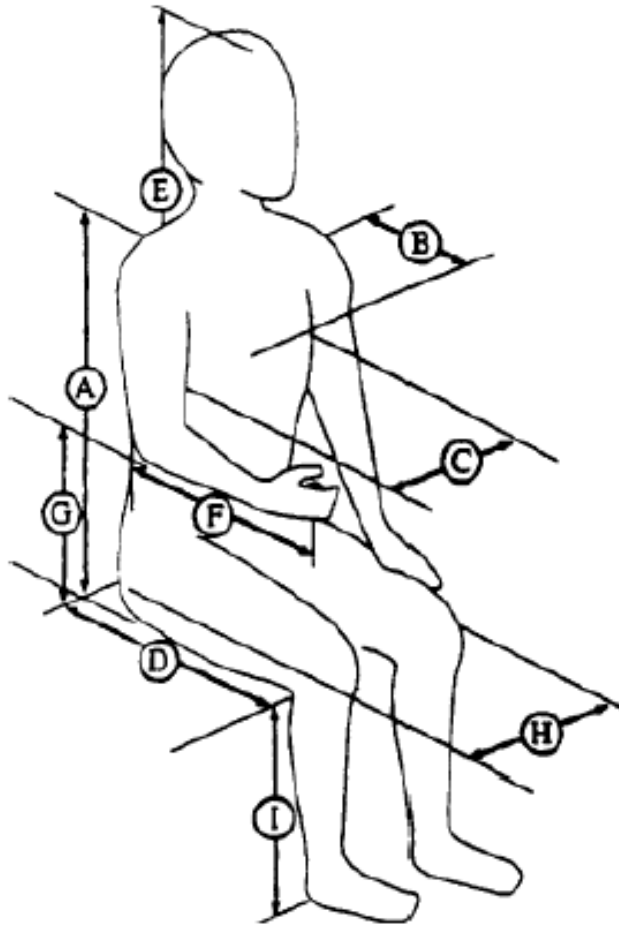


# Measurements

Client Name:



	Left	Right	Both
A: Top of Shoulders :	<input type="text"/>	<input type="text"/>	<input type="text"/>
B: Chest Depth:			<input type="text"/>
C: Chest Width:			<input type="text"/>
D: Seat Depth:	<input type="text"/>	<input type="text"/>	<input type="text"/>
E: Top of Head:			<input type="text"/>
F: Elbow to Hand:	<input type="text"/>	<input type="text"/>	<input type="text"/>
G: Seat Pan to Elbow:	<input type="text"/>	<input type="text"/>	<input type="text"/>
H: Hip Width:			<input type="text"/>
I: Knee to Foot:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Seat to Axilla:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Overall Height:	<input type="text"/>	Ft	<input type="text"/>
Overall Weight:			<input type="text"/> lbs

Comments: