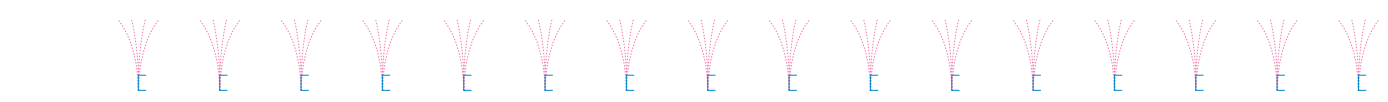
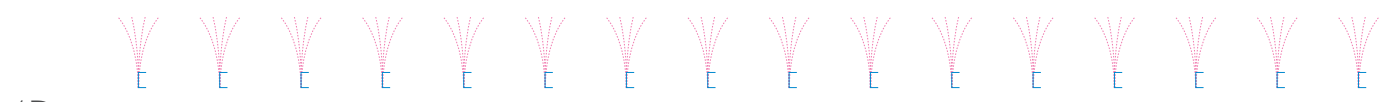
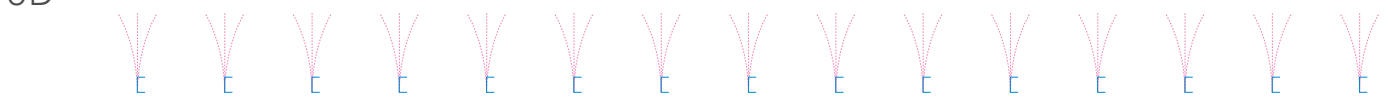
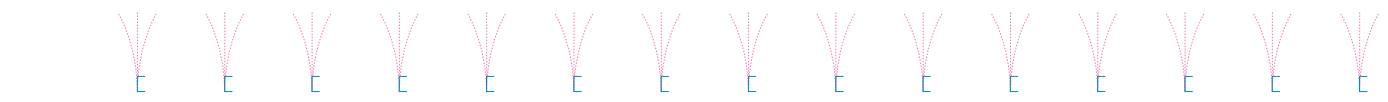
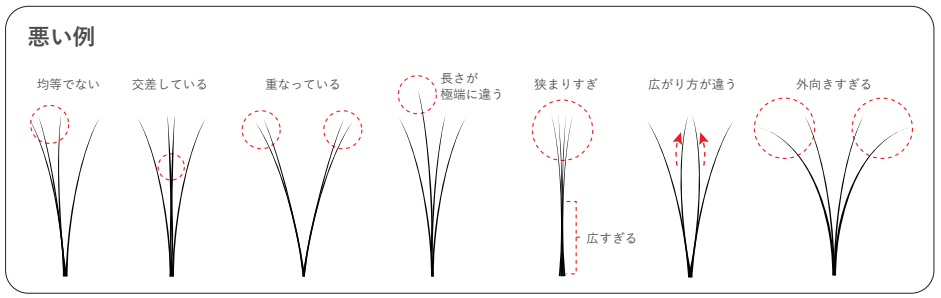
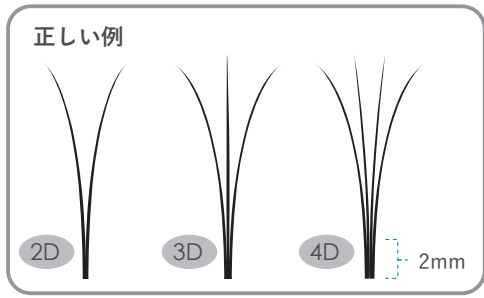


AIRY VOLUME LASH PRACTICE SHEET



Name: _____ Date: _____ Practice No: _____



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