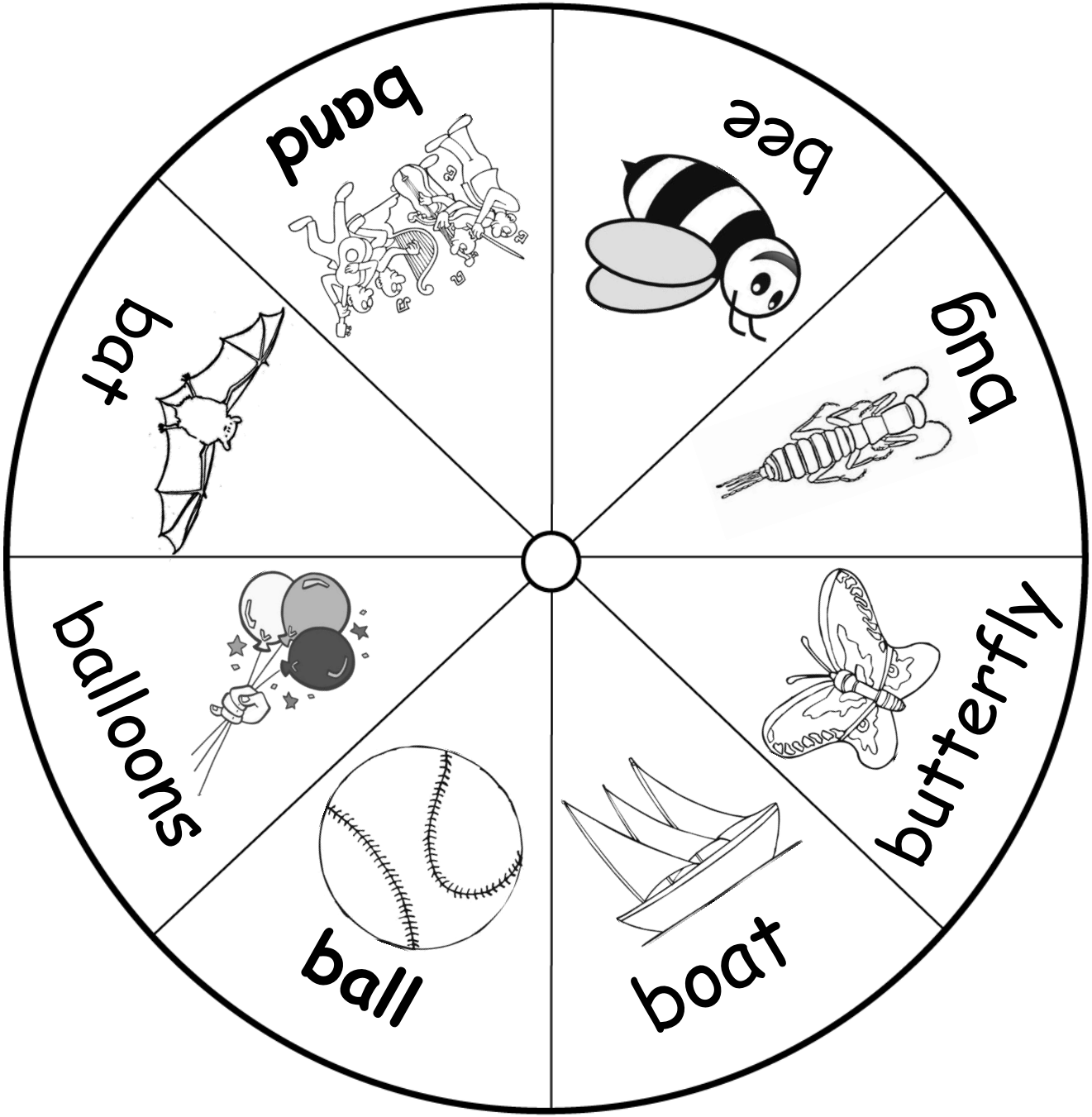
Name_____



Practice

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