

Medical Expense

Year: _____

Name: _____

S.I.N. _____

Expenses

Prescriptions: \$ _____

Dental: _____

Optical: _____

Chiropractor: _____

Other: _____

Other: _____

Other: _____

Column Total \$ _____

Total Expenses from all columns \$ _____

Travel

Accommodations

Lodging \$ _____

of days _____

of meals _____

of KM's _____

Medical Premiums \$ _____

Any Additional Information

Please attach all Medical expense receipts

