

20__ MEDICAL EXPENSE WORKSHEET

NAME _____
 SIN _____

Prescriptions:	\$ _____	\$ _____	\$ _____
Dental:	\$ _____	\$ _____	\$ _____
Optical:	\$ _____	\$ _____	\$ _____
Chiropractor:	\$ _____	\$ _____	\$ _____
Other -	\$ _____	\$ _____	\$ _____
Other -	\$ _____	\$ _____	\$ _____
Other -	\$ _____	\$ _____	\$ _____
Total Medical Expenses	\$ _____	\$ _____	\$ _____

Travel:

Accommodations	Lodging Cost	\$ _____	\$ _____	\$ _____
	# of days	_____	_____	_____
	# of meals	_____	_____	_____
	# of KM's	_____	_____	_____

Medical Premiums: \$ _____ \$ _____ \$ _____

Please attach all Medical expense receipts

SEE PAGE 2 FOR MEDICAL TRAVEL BREAKDOWN

