

20__ MEDICAL EXPENSE WORKSHEET

Pg. 1

	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