Medical Expenses from ______ /______ to ______ /______

Taxpayer's Name: ______________________ SIN # ______________

Date	Total	Reimbursed By Insurance	Net	Patient	Practioner	Treatment
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			
			$			

Total Paid by Taxpayer: **$** ________

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