DEAR

PLEASE HAVE YOUR DEPENDENT CARE PROVIDER COMPLETE THIS FORM. . YOU MUST RETURN THIS COMPLETED FORM BY (ENTER DATE) IF YOU WANT TO RECEIVE A DEPENDENT CARE DEDUCTION.

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TO BE COMPLETED BY PROVIDER

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DURING THE MONTH OF ______________, PAID ____________________
MONTH & YEAR CUSTOMER'S NAME

THE FOLLOWING AMOUNTS:

PLEASE LIST THE DATES AND AMOUNTS THE CUSTOMER PAID YOU FOR EACH CHILD OR ADULT.

CHILD'S OR ADULT'S NAME:______________________________

DATE	AMOUNT	DATE	AMOUNT
____________	$_____________	___________	$_____________
____________	$_____________	___________	$_____________
____________	$_____________	___________	$_____________
____________	$_____________	___________	$_____________

===

CHILD'S OR ADULT'S NAME:______________________________

DATE	AMOUNT	DATE	AMOUNT
____________	$_____________	___________	$_____________
____________	$_____________	___________	$_____________
____________	$_____________	___________	$_____________
____________	$_____________	___________	$_____________

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CHILD'S OR ADULT'S NAME:______________________________

DATE	AMOUNT	DATE	AMOUNT
____________	$______________	___________	$______________
____________	$______________	___________	$______________
____________	$______________	___________	$______________
____________	$______________	___________	$______________

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CHILD'S OR ADULT'S NAME:______________________________

____________	$______________	___________	$______________
____________	$______________	___________	$______________
____________	$______________	___________	$______________
____________	$______________	___________	$______________

===

NAME OF PROVIDER (PRINT) ____

SIGNATURE OF PROVIDER ____

DATE ________________ TELEPHONE NUMBER _________________________

ADDRESS ____