Name: _____

Medical Expenses

Date Paid	Name of Patient	Payment to	Description	Amount	Round trip distance (if over 40 km one way)	KM or Miles
Jan 31/18	*John Doe*	*Dr. Magoo*	*Eye specialist*	*$100.00*	*95*	*km*

Date Paid	Name of Patient	Payment to	Description	Amount	Round trip distance (if over 40 km one way)	KM or Miles
Total						

DO NOT INCLUDE EXPENSES YOU HAVE BEEN REIMBURSED FOR.

Please include travel for specialist appointments, medical tests and medical treatments.

Please include payments to private health care plans and payments for out of province coverage or country extended health care.

NOTE: TO SUPPORT MEDICAL TRAVEL, CANADA REVENUE AGENCY REQUIRES:

~ SERVICES MUST NOT BE AVAILABLE LOCALLY

~ A DOCUMENT FROM A MEDICAL PRACTITIONER SUPPORTING THE TRIP OCCURRED