

Client Name _____

Medical Expenses (amounts you paid during tax year)

Doctors, Dentists, Labs, Hospitals, Etc _____
Eyeglasses, contacts, and repairs _____
Medical Supplies IE: Wheelchair, Walker _____
Prescription Drugs _____
Miles driven to Doctors & Pharmacies _____ (miles)

Insurance Premiums (not from a pre-tax plan)

Health Insurance _____
Dental Insurance _____

Property Taxes paid during tax year (Non-Rental Home)

Sales Tax Paid on Motorized Vehicle

<u>Description of Vehicle</u>	<u>Sales Tax Paid</u>
_____	_____
_____	_____

Mortgage Interest Paid on Residence or Vacation Home (Please supply statement)

Contributions:

<u>Organization Name</u>	<u>Amount</u>
_____	_____
_____	_____
_____	_____
_____	_____

<u>Non-Cash Contributions</u>	<u>FMV Amount</u>	<u>Date</u>	<u>Original Cost</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other Miscellaneous Deductions

Tax Preparation Fee _____
Safe Deposit Box Rental Fee _____
IRA Custodial Fee (paid by check) _____
