2020 Medical Trip List

Your name: _____

All distances are in: ☐ **km** ☐ **miles**

Note: provide all parking receipts. If a receipt is not available for a trip, fill in the amount paid from bank or credit card records.

Date	Service Provider Name	Service Description	Who Trip is For	City	Distance Travelled Round Trip	Driver needed (y/n)	Parking Paid *(Receipt Not Available)*
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	
						☐ ☐	