MedicalTAX inc.
www.medicaltax.ca

MEDICAL EXPENSE CLAIM FORM

Employer's Name: _____
Employee: _____ SIN _____

Date	Description of Item or Expense	Total Amount	Amount Claimed
		SUBTOTAL	
		Administration Fee (8% of subtotal or $50.00, which ever is greater)	
		GST (5% of Administration Fee)	
		TOTAL	

I CERTIFY the above expenses were incurred by me (or my dependents) as described, qualify under the PHSP provisions of the Income Tax Act and the portion claimed has not and will not be covered under any other plan.
Dated _____, 201___

_____
Employee's signature

NOTE: Make Cheques Payable to MedicalTAX Inc.

1403B – 2nd St SW Calgary, AB, T2R 0W7
ph:: **403-228-7825** fax:: 403-228-7925

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