DEPENDENT CARE RECEIPT

Dates of Service: _____ Amount Charged: _____

Names of Dependents: _____

Service Provider Info:

Name of Provider: _____

Address: _____

City/State/Zip: _____

SS# or TAX ID #: _____

_____

Child Care Provider's Signature Date

The receipt must be attached to a REQUEST FOR REIMBURSEMENT FORM.

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