DEPENDENT CARE RECEIPT

Receipt Date: _____

_____
(Provider Name)

_____
(Provider Address)

_____
(Provider Telephone Number)

Provider Signature: _____

Child Care Services Provided for:

_____
(Guardsman Name)

_____
(Guardsman Address)

_____
(Guardsman Telephone Number)

Date of Payment Made to Provider: _____

Date of Care	Name of Dependent	Age of Dependent	Cost of Care
		Total	