**MEDICAL DEDUCTIONS WORKSHEET**

**TAXPAYER NAME(S):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TAX YEAR:\_\_\_\_\_\_\_\_\_\_\_**

**\*PLEASE TOTAL YOUR RECEIPTS FOR EACH CATEGORY AND WRITE THE TOTAL IN THE SPACE PROVIDED.**

**OUT-OF-POCKET INSURANCE PREMIUMS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESCRIPTIONS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOCTOR/DENTIST PAYMENTS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LAB/X-RAY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EQUIPMENT/SUPPLIES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EYEGLASSES/CONTACT LENSES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TRAVEL:**

 **LODGING \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **AIRFARE, BUS, RENTAL CAR, ETC. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **MEALS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **MILEAGE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**