

**2010-2011**

Return to:  
 Claremont McKenna College  
 Financial Aid Office  
 890 Columbia Avenue  
 Claremont, CA 91711-6425  
 (909) 607-0661 FAX  
 finaid@claremontmckenna.edu

Name of Student Applicant (Please Print):		
Last	First	Middle
ID Number: _____		

**PARENT(S) 2009 MEDICAL/DENTAL EXPENSE FORM**

The Financial Aid Office requires the following information to verify the medical/dental expenses your parent(s) reported on your 2010-2011 financial aid application.

Please list all out-of-pocket medical/dental expenses that were paid in the year 2009. You may include the cost of medical/dental insurance premiums, but do not include any costs reimbursed by any insurance company. **Attach documentation of paid medical or dental expenses to this form.**

Name of the Person/Agency Paid	Date Paid	Amount Paid
_____	_____ \$	_____
_____	_____ \$	_____
_____	_____ \$	_____
_____	_____ \$	_____
_____	_____ \$	_____
_____	_____ \$	_____
_____	_____ \$	_____
_____	_____ \$	_____
_____	_____ \$	_____
_____	_____ \$	_____
<b>Total 2009 Medical/Dental Expenses</b>		<b>\$ _____</b>

\_\_\_\_\_  
 Mother's/Stepmother's Signature      Date

\_\_\_\_\_  
 Father's/Stepfather's Signature      Date