CLIENT NAME:_____

ITEMIZED DEDUCTIONS	**AMOUNT**
MEDICAL EXPENSES	**$**
PRESCRIPTION MEDICATION	
FEES FOR DOCTORS AND DENTIST	
HOSPITAL FEES	
LAB AD X-RAY FEES	
MEDICAL AIDS SUCH AS:	
eye glasses, contact lenses, hearing aids, cluches, and wheelchair etc	
TOTAL	
GIFTS BY CASH OR CHECK	
TOAL TO SCHEDULE A LINE 15	
GIFTS OTHER THAN CASH OR CHECK	
TOTAL TO SCHEDULE A LINE 16	
UNREIMBURSED EMPLOYEE EXPENSE	
TRAVEL Expense including Tolls and Parking cost	
UNION AND PROFESSIONAL FEE	
PROFESSIONAL SUBSCRIPTION	
UNIFORM AND PROTECTIVE CLOTHING	
JOB SEARCH COST	
MISC. EXPENSES	
Job Training	
TOTAL TO SCHEDULE A LINE 20	
DATE:_____ ***TAX PAYERS' SIGNATURE: _____***	