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2008-2009

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) 2007 MEDICAL/DENTAL EXPENSE FORM

The Financial Aid Office requires the following information to verify the medical/dental expenses your parent(s) reported on your 2008-2009 financial aid application.

Please list all out-of-pocket medical/dental expenses that were paid in the year 2007**.** 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
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
	Total 2007 Medical/Dental Expenses	**$**_____

_____ _____

Mother's/Stepmother's Signature Date

_____ _____

Father's/Stepfather's Signature Date