CMC Student's Full Name:	
CMC Student ID#	

Parent(s) 2017 Medical/Dental Expense Form

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

Please list all out-of-pocket medical/dental expenses that were paid in the year 2017**.** 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.**

Note: Allowances of these medical/dental expenses are subject to verification and must exceed 4.9% of total income which is adjusted gross income, taxable, and untaxed income.

Name of the Person/Agency Paid	Date Paid	Amount Paid
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
		$
Total 2017 Medical/Dental Expenses		$

Parent 1/Stepparent 1 Signature _____ Date _____

Parent 2/Stepparent 2 Signature _____ Date _____

Return to: ***Fax:*** *(909) 607-0661* ***Email:*** *finaid@cmc.edu* ***Phone:*** *(909) 621-8356*
Office of Financial Aid, Claremont McKenna College, 888 Columbia Avenue, Claremont, CA 91711