RECEIPT FOR DAY CARE SERVICES

Paid By: For: _____

Paid to (Provider Name): _____

Address: _____

_____

Social Security Number: _____

Taxpayer Identification Number: _____

AMOUNT PAID: _____

For Dates: From _____ To _____ 20__

(Month/Day) (Month/Day)

SIGNATURE OF PROVIDER: _____

RECEIPT FOR DAY CARE SERVICES

Paid By: For: _____

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