DAY CARE PROVIDER_____

ADDRESS_____

_____

TAX ID NUMBER, SOCIAL SECURITY NUMBER OR STATEMENT THAT PROVIDER IS TAX EXEMPT

_____

DAY CARE SERVICES FOR THE WEEK OF MONTH ENDING_____

(IF THE PROVIDER REQUIRES PAYMENT WHETHER THE CHILD ATTENDS OR NOT, THEN A MONTHLY STATEMENT OF COST IS APPROPRIATE. IF THE PROVIDER DOES NOT REQUIRE PAYMENT WHEN THE CHILD IS NOT IN DAY CARE, A WEEKLY RECEIPT IS APPROPRIATE.)

DAY CARE AT THE RATE OF $_____PER DAY OR PERWEEK.

TOTAL FOR THE MONTH $_____

SIGNATURE OF DAY CARE PROVIDER_____

EMPLOYEE'S SIGNATURE_____