



DEPARTMENT OF HEALTH AND HUMAN SERVICES
STATEMENT OF RECEIPTS FROM APPLICANTS
NATIONAL DENTAL DAY FUND

Applicant Name: _____ Date: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____

1. Name of Applicant: _____
 2. Address: _____
 3. City: _____ State: _____ Zip: _____
 4. Name of Applicant: _____
 5. Address: _____
 6. City: _____ State: _____ Zip: _____

NO	DATE	AMOUNT	REMARKS
1	5/1	100.00	
2	5/1	100.00	
3	5/1	100.00	
4	5/1	100.00	
5	5/1	100.00	
6	5/1	100.00	
7	5/1	100.00	
8	5/1	100.00	
9	5/1	100.00	
10	5/1	100.00	
11	5/1	100.00	
12	5/1	100.00	
13	5/1	100.00	
14	5/1	100.00	
15	5/1	100.00	
16	5/1	100.00	
17	5/1	100.00	
18	5/1	100.00	
19	5/1	100.00	
20	5/1	100.00	

TOTAL: \$1000.00
 Date: _____

Signature of Applicant: _____
 Signature of Secretary: _____



2010/2011
 On _____