HOSPITAL NAME HERE

Street Address:
City, State, ZIP:
Phone:
Email:

CASH RECEIPT

Date: _____ Receipt Num:_____

Amount Received From: _____

Address: _____

_____

Amount: _____

Purpose of Payment: _____

_____

Account	
Total Amount Due	
Amount Paid	
Balance Due	

Payment Made BY	
Cash	
Cheque	
Others	

Amount Received by: _____

_____ _____

Authorized Signatures Authorized Signatures