



Clinic Income/Expense Form

Clinic _____ Date _____

Clinic Organizer _____

	Participant Name	Clinic Fee	Membership*	Stabling	AEF #
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					

*Please fill out membership form

Income

1. Total Clinic Fees	\$ _____	
2. SPHC Subsidy	\$ _____	
Sub total	\$ _____	
3. Other Income		
Membership	\$ _____	
Stabling	\$ _____	
Other	\$ _____	Specify _____
Sub total	\$ _____	
TOTAL INCOME		\$ _____

Expenses

1. Clinician Fees	\$ _____	
	\$ _____	
	\$ _____	
Sub total	\$ _____	
2. Clinician Travel Expenses	\$ _____	
	\$ _____	
	\$ _____	
Sub total	\$ _____	
3. Clinician Expenses	\$ _____	
	\$ _____	
	\$ _____	
Subtotal	\$ _____	
4. Facility Rental	\$ _____	
5. Stabling	\$ _____	
TOTAL EXPENSES		\$ _____
PROFIT		\$ _____
LOSS		(\$ _____)