FIRST NATION MEDICAL BOARD

2121 E. Flamingo Rd., Suite 112, Las Vegas, NV 89119

Tribal Donation Form*

DATE: _____

PROVIDER: _____

LOCATION: _____

MONTH	TOTAL REVENUES	TRIBAL DONATION (5%)
JANUARY		
FEBRUARY		
MARCH		
APRIL		
MAY		
JUNE		
JULY		
AUGUST		
SEPTEMBER		
OCTOBER		
NOVEMBER		
DECEMBER		
TOTALS:	$_____	$_____

I hereby certify that this return including any accompany schedule and statements has been examined by me and to the best of my knowledge and belief is a true and correct complete return:

SIGNATURE: _____

*The above-named Provider must provide a summary of 5% Tribal Donations collected from Provider's indigenous medical services and sales. Tribal Donations must be paid annually to "FNMB" prior to Provider's tribal license being renewed.