



HEALTH MINISTRIES ASSOCIATION

Chapter Annual Financial Report (Due January 31st)

Chapter Name: _____ Year: _____

Treasurer: _____

Address: _____

City/State/Zip: _____

E-mail: _____

Day Phone: _____ Evening Phone: _____

INCOME

EXPENSES

Local Membership Fees: \$ _____

Office Expenses: \$ _____

Workshop/Seminar Fees: \$ _____

Program Costs: \$ _____

Contributions: \$ _____

Speaker Fees: \$ _____

Sponsorships: \$ _____

Food: \$ _____

Interest: \$ _____

Travel Expenses: \$ _____

Other: (list) _____ \$ _____

Other: (list) _____ \$ _____

_____ \$ _____

_____ \$ _____

(Attach additional pages as necessary)

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Total Income \$ _____

Total Expenses \$ _____

List All Chapter Accounts

INSTITUTION	ACCOUNT TYPE	ACCOUNT #	BALANCE
1. _____			
2. _____			

Start of Year Net Worth \$ _____

End of Year Net Worth \$ _____