Saint Francis Medical Center College of Nursing
Student Finance Office
511 NE Greenleaf Street Peoria, IL 61603

STATEMENT OF CHILD SUPPORT PAID

This is to certify that I (We) paid Child Support Benefits for the Calendar year 2015:

	Name of Person Who Paid the Child Support (*Full Name*)	Name of Person to Whom Child Support Was Paid (*Full Name*)	Name & Age of Child for Whom Support was Paid (*Full Name*)	Amount of Child Support Paid in 2015
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

_____ _____
Financial Aid Applicant Date

_____ _____
Payee Signature Date