

2024 Medical Professional TAX RETURN QUESTIONNAIRE



Personal Details

Be sure to save your information as you complete the form.

Full Name:

D.O.B.:

Current Address:

Contact Number:

Email:

Tax File Number:

Occupation:

Bank BSB:

Account Number:

Spouse Details

Did you have a spouse during the financial year? Yes No

(If no spouse skip to Income section.)

Spouse's Name:

Spouse's D.O.B.:

No. of Dependents:

Spouse Taxable Income:

For the full year, was your spouse and dependants covered by private hospital cover? Yes No

Income

No. of employers:

Total Bank Interest Earned:

Did you receive any additional income? Yes No

If yes, please tick all that apply

Rental Income

Small Business

Shares Dividends/Sales

Foreign Income

Crypto Investments

Managed Funds/ETF

Other:

**Please specify*

Preferred Payment Method:

Credit Card

Fee From Refund

2024 Medical Professional TAX RETURN QUESTIONNAIRE

Deductions:

Please Note: You need to retain any receipts for deductions that you have claimed.

1. Work Related Travel (Does not include commute to and from work)

Do you salary sacrifice your vehicle? Yes No

Estimated Kms Travelled: Car Make/Model:

Description of work travel:

2. Uniform Expenses

Logo/Protective Uniforms

Non-Slip Shoes

3. Professional Expenses

AHPRA Fees

Conference Expenses

Union Fees

Other Professional Memberships

4. Communication

Monthly Mobile Plan % used for income earning purposes?

Monthly Internet Plan % used for income earning purposes?

Total Home Office Hours logged working from home?

5. Work Equipment/Tools

Description	Cost	% Work Use	Description	Cost	% Work Use
-------------	------	------------	-------------	------	------------

6. Other Work Related Deductions

Donations

Stationery

Tax Agent Fee from prior year

Other *(Please specify)*

* This is a general questionnaire to commence your individual tax return, more information may be required if you have other income sources.

* Please note that you need to retain any receipts for deductions that you have claimed.

* Please list any additional income/deductions not covered by this questionnaire in the body of your email.