Minnesota Department of Health Establishment License #

# Mortuary Science Pre-Need Trust Ledger

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Purchaser** | **Beneficiary** | **Amount of funds originally deposited** | **Current Balance** | **Deposit + This Year** | **Interest + This Year** | **Withdrawals + This Year** | **Account No./ Location** |
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**All fields below must be completed or this form will be mailed back to you.**

Beginning Balance – January 1 $

Add: Deposits and Interests $

Less: Withdrawals and Refunds $

Ending Balance – December 31 $

Subscribed and sworn to before me this day of , .

Notary Public Signature

*I,*

Name Title

*hereby certify that the information contained in this report is true and correct to the best of my knowledge and contains a complete and accurate report of all pre-need trust funds for the licensed establishment or funeral provider listed. I further certify that I am authorized to submit this report on behalf of .*

Signature Date

Minnesota Department of Health | Mortuary Science Section | PO Box 64882 | St. Paul, MN 55164-0882 | 651-201-3829 | [health.mortsci@state.mn.us](mailto:health.mortsci@state.mn.us)

2/11/20

To obtain this information in a different format, call: 651-201-3829.