

**APPLICATION FOR CERTIFICATION OF ELIGIBILITY
OREGON STATE PERSONAL INCOME TAX CREDIT**

ORS 316.117 – VOLUNTEER* EMT

Please note: this is a fillable form. Please type your responses on the lines provided. You can tab from field to field.

This application is for **TAX** year **2007**

Part I.

1. Full name of applicant (First, middle initial, last):

2. HOME Mailing address: _____
City: _____ State: _____
Zip: _____ County: _____
3. Email: _____
4. Daytime phone: _____
5. Social Security Number: _____

OFFICE OF RURAL	
RECEIVED:	REVIEWED:
INITIAL	FINAL
<input type="checkbox"/> Pending	<input type="checkbox"/> Denied
<input type="checkbox"/> Approved	<input type="checkbox"/> Approved

Part II.

1. Are you an Oregon certified Emergency Medical Technician? ____yes ____no
(If you checked "no", you are not eligible for this tax credit)

**A "volunteer" is a person properly trained under Oregon law who either operates an ambulance to and from the scene of an emergency or renders emergency medical treatment on a volunteer basis so long as the total reimbursement received for such volunteer services does not represent more than 25% of his or her gross annual income, not to exceed \$3,000 per calendar year.*

2. How many hours during 2007 did you provide EMT services in Oregon? (include stand-by, response, and training time)

Paid hours in 2007 _____ Volunteer hours in 2007 _____

3. From what station or agency do you currently provide volunteer EMT services?

Station/Agency: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip code: _____

Station or agency telephone: (_____) _____ - _____

4. Did you relocate your volunteer services during 2007? YES NO

If yes, please list any other station or agency locations during 2007:

Street Address: _____

City: _____ County: _____ State: _____ Zip code: _____

Date of relocation: _____

I attest that the information provided on this application is true and accurate:

Applicant name (please print): _____

Applicant signature _____ Date _____

EMS Supervisor name (please print): _____

EMS Supervisor signature _____ Date _____

PLEASE SIGN AND DATE ABOVE

FAX TO: 503-494-4798

OR

EMAIL TO: jordane@ohsu.edu

OR

**MAIL TO: Oregon Office of Rural Health
Oregon Health & Science University
3181 SW Sam Jackson Pk Rd – L593
Portland, OR 97239**