

# 2011-2012 Application for Certification of Eligibility

## Oregon Volunteer\* EMS Provider Tax Credit - ORS 316.622

This form is electronic. If possible, please fill out as much on the computer as one can before printing and signing.

### Applicant

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_  
(First, M.I., Last—please print legibly.) (Please print legibly—this is how we send confirmations.)

Social Security Number: \_\_\_\_\_ Daytime Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home Mailing Address:

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

### EMT Status

1. Are you an Oregon certified Emergency Medical Services Provider?  Yes  No

**(If you checked "No", you are not eligible for this tax credit.)**

2. How many hours during 2012 did you provide EMS Provider services in Oregon? (Include all stand-by, response, and training time.)

Paid Hours: \_\_\_\_\_ Volunteer Hours: \_\_\_\_\_

\*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.

### Primary Station/Agency (Supervisor signature required below.)

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Partial year status:  Started  Stopped Date: \_\_\_\_\_  
(Month/Year)

### Secondary Station/Agency (If applicable.)

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

### Tertiary Station/Agency (If applicable.)

Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

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

\_\_\_\_\_  
Applicant Signature Date: \_\_\_\_\_

Primary Agency EMS Provider Supervisor Name (please print): \_\_\_\_\_

Primary Agency EMS Provider Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_