2013-2014 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 **2014** 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: (_____) _____ - _____

_____

Streeet Address City State ZIP

Secondary Station/Agency (If applicable.)

Name: _____ Phone: (_____) _____ - _____

_____

Streeet Address City State ZIP

Tertiary Station/Agency (If applicable.)

Name: _____ Phone: (_____) _____ - _____

_____

Streeet Address City State ZIP

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

_____ Date: _____

Applicant Signature

Primary Agency EMS Provider Supervisor Name (please print): _____

Primary Agency EMS Provider Supervisor Signature: _____ Date: _____

Either fax the completed form to (503) 494-4798,
or mail to: Oregon Office of Rural Health | 3181 SW Sam Jackson Park Rd., L-593 | Portland, OR 97239