

RENEWAL FORM

Oregon Volunteer EMS Provider 2013-2014 Tax Credit Certification

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

EMS Provider		
Name: _____ (First, M.I., Last - please print legibly.)		
Signature: _____		
E-mail: _____ (Please print legibly--this is how we send confirmations.)		
Last four numbers of S.S.: _____		
Daytime Phone: (____) _____ - _____		
New mailing address as of <u>2014</u> :		
Street Address _____		
City _____	State _____	ZIP _____

Status
<input type="checkbox"/> My Primary Station/Agency location (city) has not changed during <u>2014</u> .
<input type="checkbox"/> My Total Volunteer Hours have changed : Paid Hours: _____ Volunteer Hours: _____
<input type="checkbox"/> I retired as a volunteer EMS Provider on: _____, <u>2014</u> . (Mo./Day)
<input type="checkbox"/> I moved to a different state on _____, (Mo./Day) <u>2014</u> and no longer volunteer as an EMS Provider in Oregon.
<input type="checkbox"/> I moved back to Oregon from a different state on _____, <u>2014</u> and now volunteer. * (Mo./Day)
<input type="checkbox"/> As of _____, <u>2014</u> , I now volunteer in a different city in Oregon . *
* New Station/Agency information on the right is required for these fields only.

Station/Agency (Complete only if applicable. Please print legibly.)
New Primary Station/Agency
Name: _____
Street: _____
City: _____
State: OR Zip: _____
Phone: (____) _____ - _____
EMS Provider Supervisor Printed Name: _____
EMS Provider Supervisor Signature: _____
New Secondary Station/Agency
Name: _____
Street: _____
City: _____
State: OR Zip: _____
Phone: (____) _____ - _____
New Tertiary Station/Agency
Name: _____
Street: _____
City: _____
State: OR Zip: _____
Phone: (____) _____ - _____

**Either fax 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**