RENEWAL FORM

Oregon Volunteer EMS Provider **2016** 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 home mailing address as of 2016:

____

Street Address

____

City State ZIP

Status

☐ My Primary Station/Agency location (city) **has not changed** during 2016.

☐ My Total Volunteer Hours **have changed**:
Paid Hours: _______ Volunteer Hours: ________

☐ I **retired** as a volunteer EMS Provider on:
_________,2016.
(Mo./Day)

☐ I **moved to a different state** on _________,
(Mo./Day)
2016 and no longer volunteer as an EMS Provider in Oregon.

☐ I **moved back to Oregon** from a different state on _________, 2016 and now volunteer. ✱
(Mo./Day)

☐ As of ________, 2016, I now **volunteer in a**
(Mo./Day)
different city in Oregon. ✱

✱ **New Station/Agency information on the right is required for these fields only.**

Station/Agency

(Complete only if there were changes in 2016. 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