

2017 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 2017 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 _____

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: _____