

2018 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

- Are you an Oregon certified Emergency Medical Services Provider? Yes No
Please indicate your Oregon license: EMR EMT AEMT EMT-I Paramedic
- How many hours during 2018 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: _____