

# 2017 New Application

## Rural Practitioner Tax Credit

### Practitioner

\*Name: \_\_\_\_\_ \*Social Security: \_\_\_\_\_  
(Your name used on taxes)

\*Email: \_\_\_\_\_ \*Your daytime phone: \_\_\_\_\_

\*Specialty: \_\_\_\_\_ \*License number: \_\_\_\_\_

\*Licensure: CRNA<sup>^</sup>  | DDS<sup>^</sup>  | DMD<sup>^</sup>  | DO<sup>^</sup>  | DPM<sup>^</sup>  | MD<sup>^</sup>  | NP  | PA  | OD<sup>^</sup>

\*Home address (the home address used on taxes)

\_\_\_\_\_  
\*Street \_\_\_\_\_ \*City

\_\_\_\_\_  
\*County \_\_\_\_\_ \*State \_\_\_\_\_ \*Zip Code

**\*Individual adjusted gross income does not exceed \$300,000 for the tax year.**

It **does not** exceed  It **does** exceed

*(If your 2020 **individual** adjusted gross income is in excess of \$300,000, you are not eligible to claim this credit for tax year 2020. The only exceptions are for a physician who practices as a general surgeon, specializes in obstetrics or specializes in family or general practice and provides obstetrical services.)*

### Oregon Practice Sites

\*Site 1: \_\_\_\_\_  
\*Name

\_\_\_\_\_  
\*Street \_\_\_\_\_ \*City

\_\_\_\_\_  
\*County \_\_\_\_\_ \*Zip Code

**\*List the hours practiced in an average work week at this site.** An average work week is factored by dividing the monthly total hours by 4. **DO NOT LIST MONTHLY TOTALS**

Jan:	Feb:	Mar:	Apr:	May:	Jun:
Jul:	Aug:	Sep:	Oct:	Nov:	Dec:



# 2020 New Application

## Rural Practitioner Tax Credit

Site 2: \_\_\_\_\_  
Name

\_\_\_\_\_  
Street City

\_\_\_\_\_  
County Zip Code

List in the hours practiced in an average work week at this site. An average work week is factored by dividing the monthly total hours by 4. **DO NOT LIST MONTHLY TOTALS**

Jan:	Feb:	Mar:	Apr:	May:	Jun:
Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

Site 3: \_\_\_\_\_  
Name

\_\_\_\_\_  
Street City

\_\_\_\_\_  
County Zip Code

List the hours practiced in an average work week at this site. An average work week is factored by dividing the monthly total hours by 4. **DO NOT LIST MONTHLY TOTALS**

Jan:	Feb:	Mar:	Apr:	May:	Jun:
Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

*If you have more than 3 sites, please include them formatted exactly as above on additional paper.*

\* I hereby confirm that throughout the tax year I was **willing** to serve patients with Medicare and Medicaid coverage in the same proportion to the total number of Medicare and Medicaid recipients in the practice's county, up to 20 percent Medicare patients and 15 percent Medicaid patients.

\_\_\_\_\_ Yes \_\_\_\_\_ No

\*Signature: \_\_\_\_\_



# 2020 New Application

## Rural Practitioner Tax Credit

**^ \*CRNA & DPM:** include a letter from an eligible hospital on their letterhead verifying your personal employment or contractual status with that eligible hospital.

**^ \*DDS & DMD:** If there is a hospital in your community, you must have a verifiable agreement with that hospital to provide emergency dental services. Please provide the following information:

\_\_\_\_\_  
Name of hospital (if applicable) City

\_\_\_\_\_  
Verification contact name Phone

The following attestations are required for dentists accepting this tax credit. Please check each one that is applicable (1 & 2 or 1 & 3).

1. \_\_\_\_ I hereby confirm my willingness to reasonably accommodate the oral health needs of patients in my rural community regardless of the source of payment for their care; AND

2. \_\_\_\_ I hereby confirm that I have a verifiable written agreement with the rural hospital in my community to treat emergency dental patients either on the hospital premises or in my operatory regardless of the source of payment for their care; OR

3. \_\_\_\_ There is no hospital in my rural community.

**^ \*DO & MD:** If you are on **active staff** of **any** Oregon hospital, please list:

\_\_\_\_\_  
Name of hospital City

**^ \*OD:** You must have verifiable consulting privileges with an eligible rural hospital **unless** you practice a minimum of 20 hours per week or more in a Frontier county. If you **do not** practice in a Frontier county, please provide the following information:

\_\_\_\_\_  
Name of hospital City

\_\_\_\_\_  
Verification contact name Phone

**Make \$45.00 check payable to:** Oregon Office of Rural Health

**Mail check and renewal form to:** Oregon Office of Rural Health  
3181 SW Sam Jackson Park Rd, L593  
Portland OR 97239

