2020 Renewal Form

Rural Practitioner Tax Credit

Practitioner

*Name: _____ *Last 4 of Social Security: _____
(Your name used on taxes)

*Email: _____ *Your daytime phone: _____

*Specialty: _____ *License number: _____

I have retired ☐ I no longer practice in rural Oregon ☐

New home address in 2020

_____ _____
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:

Required

2020 Renewal Form

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: _____

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

**** Required***