

2021 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 2021

 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 2021 individual adjusted gross income is in excess of \$300,000, you are not eligible to claim this credit for tax year 2021. 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:



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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

