

RENEWAL FORM

Oregon Volunteer EMS Provider 2015 Tax Credit Certification

This form is electronic. If possible, please fill out as much on the computer as one can before printing and signing.

EMS Provider		
Name: _____ (First, M.I., Last - please print legibly.)		
Signature: _____		
E-mail: _____ (Please print legibly--this is how we send confirmations.)		
Last four numbers of S.S.: _____		
Daytime Phone: (____) _____ - _____		
New mailing address as of 2015:		
Street Address		
City	State	ZIP

Status
<input type="checkbox"/> My Primary Station/Agency location (city) has not changed during 2015.
<input type="checkbox"/> My Total Volunteer Hours have changed : Paid Hours: _____ Volunteer Hours: _____
<input type="checkbox"/> I retired as a volunteer EMS Provider on: _____, 2015. (Mo./Day)
<input type="checkbox"/> I moved to a different state on _____, (Mo./Day) 2015 and no longer volunteer as an EMS Provider in Oregon.
<input type="checkbox"/> I moved back to Oregon from a different state on _____, 2015 and now volunteer. * (Mo./Day)
<input type="checkbox"/> As of _____, 2015, I now volunteer in a different city in Oregon . *
* New Station/Agency information on the right is required for these fields only.

Station/Agency (Complete only if applicable. Please print legibly.)
New Primary Station/Agency
Name: _____
Street: _____
City: _____
State: OR Zip: _____
Phone: (____) _____ - _____
EMS Provider Supervisor Printed Name:

EMS Provider Supervisor Signature:

New Secondary Station/Agency
Name: _____
Street: _____
City: _____
State: OR Zip: _____
Phone: (____) _____ - _____
New Tertiary Station/Agency
Name: _____
Street: _____
City: _____
State: OR Zip: _____
Phone: (____) _____ - _____

**Either fax completed form to (503) 494-4798 or mail to:
Oregon Office of Rural Health | 3181 SW Sam Jackson Park Rd., L-593 | Portland, OR 97239**