

STATUS: RENEWAL _____ NEW _____



APPLICATION FOR TAX EXEMPTION FOR AMBULANCE-TYPE MOTOR VEHICLES

GS 12-81C/ MCC187-6

20__ GRAND LIST

LAST NAME

FIRST NAME

ADDRESS

1. Description of vehicle for which exemption is requested.

MAKE MODEL YEAR REG.NO. V.I.N.

2. Is this vehicle used exclusively for transporting the medically incapacitated individuals?

YES _____ NO _____

3. The location and description of the place or places from which vehicle is intended to operate:

4. Is any payment received for transporting the medically incapacitated persons?

YES _____ NO _____

5. Describe in detail the modifications or special equipment (i.e. lifts, hand controls, etc.) which are required to accommodate the incapacitated persons.

6. Cost of modifications. \$ _____ New vehicle applications must attach Invoice for cost of modifications.

7. APPLICANT'S AFFIDAVIT

I the undersigned claim tax exemption under provisions of the Connecticut General Statutes 12-81 C and the Meriden City Code 187-6. I do hereby declare under penalties of false statement that the information provided is a complete and true statement attributable to the above-identified property.

SIGNATURE OF APPLICANT:

DATE SIGNED:

TELEPHONE NUMBER:

ASSESSOR'S AFFIDAVIT

Approved _____ Exemption Amount Approved _____

Not Approved _____ Reason denied _____

SIGNATURE OF ASSESSOR

OR MEMBER OF ASSESSOR'S STAFF _____ DATE _____