APPLICATION FOR TAX EXEMPTION FOR AMBULANCE-TYPE MOTOR VEHICLES

GS 12-81C **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. **Is any payment received for transporting the medically incapacitated persons?**

   YES _____ **NO** _____

4. **Describe any modifications or special equipment (i.e. lifts, hand controls, etc.) which were required to accommodate the incapacitated persons.**

   _____

   _____

5. **Estimate the cost of these modifications.** **$**_____

6. **APPLICANT'S AFFIDAVIT**
   The applicant herein claims a tax exemption under provisions of the State General Statutes and the Town ordinance and certifies that the above statements are true and complete.

SIGNATURE OF APPLICANT:

DATE SIGNED: **TELEPHONE NUMBER:**

ASSESSOR'S AFFIDAVIT

Approved _____ **Exemption Amount Approved** _____

Not Approved _____

SIGNATURE OF ASSESSOR
OR MEMBER OF ASSESSOR'S STAFF_____ **DATE**_____