Office Of The Assessor
2725 Main Street, Stratford, CT 06615
Phone: 203-385-4025 Fax; 203-395-4067
www.townofstratford.com

APPLICATION FOR TAX EXEMPTION FOR AMBULANCE-TYPE MOTOR VEHICLES

GS 12-81C _______ **GRAND LIST**

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.**

   ____

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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**_____________