



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.

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 _____