

**COOPER/SAMS VOLUNTEER AMBULANCE PROGRAM
 AWARD CLAIM APPLICATION**

*This form must be received in the EMSRB office by October 1, 2017
 to be paid about April 1, 2018*

APPLICATION INSTRUCTIONS:

Applicant Information

1. Provide applicant's name - last, first, middle.
2. Provide applicant's Social Security number.
3. Provide applicant's current address - street, city, state and zip code.
4. Provide applicant's date of birth.
5. List any and all names under which applicant's service may be registered.
6. Provide e-mail address to receive notification claim application was received by EMSRB
7. Applicant must sign and date form.
8. Ambulance director must sign and have the form notarized.

Completed form must be mailed along with the attached and completed W-9 form to the EMSRB office at the address above.
 Note: You will receive a confirmation of receipt within two weeks of submission to our office. If you do not receive it, please contact the EMSRB office at 651-201-2800 or 800-747-2011.

Applicant Information

The information supplied below is for internal use by the EMSRB. You are not legally required to provide all of the information, but if you choose not to the EMSRB will be unable to calculate your award payment without it.

1. Applicant Name (Last, First, Middle)	2. Social Security Number
3. Current Mailing Address (please include city and zip code)	
4. Date of Birth	5. List all former last name(s)
6. E-mail Address	

7. I certify that I have terminated active ambulance service, am I at least 50 years of age, and I have at least five years of credited ambulance service in the Ambulance Service Personnel Longevity Award and Incentive Program. The information I have provided on this form is true and correct.

Applicant Signature	Date
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8. The affidavit below must be signed by the chief administrative officer of ambulance service and then notarized.

STATE OF MINNESOTA)
 County of _____)

Affidavit of Termination of Service

_____, being first duly sworn, attest that to the best of the affiant's knowledge and belief, the person named **(Name of chief administrative officer)** above, who is applying for an Individual Longevity Award, has terminated from active service on the service for which the affiant's speaks and meets the qualifications for the Longevity Award in Minnesota Statutes 144E.46. Further, affiant says the information contained on this form is true and correct to the best of the affiant's ability. Further, affiant sayeth not.

Chief Administrative Officer Signature	Notary Public Signature
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Subscribed and sworn before me this ____ day of _____, 20____.

PLEASE BE ADVISED! Collecting a Cooper/Sams Volunteer Ambulance Award may have Federal, State, or other tax implications. The EMSRB asks you to please consult your tax professional before proceeding to request an award payout. The EMSRB will not counsel you on tax related matters.