

**PENNSYLVANIA
 ORGAN & BONE MARROW DONOR
 TAX CREDIT**



BUSINESS FIRM INFORMATION – (PLEASE PRINT OR TYPE)	Account ID (Box Number/SSN)	Entity ID (EIN)
Entity Name	Entity Type	
Street Address	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Bank or Trust Company <input type="checkbox"/> Partnership <input type="checkbox"/> Title Insurance Company <input type="checkbox"/> Estate/Trust <input type="checkbox"/> Insurance Company <input type="checkbox"/> PA S Corporation <input type="checkbox"/> Mutual Thrift <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company	
City or Town, State and ZIP Code		

COMPUTATION OF CREDIT

1. Tax Period Beginning Date _____ Tax Period Ending Date _____
2. Number of employees donating an organ or bone marrow during tax year 2007 _____.
3. Use the table below to itemize each employee’s compensation paid during an absence to donate an organ or bone marrow. If more than three employees donated organs or bone marrow, please include a separate sheet detailing the information shown below for additional employees.

Employee Last Name, First Name	SSN	Beginning Date of Absence	Ending Date of Absence	Employee Compensation
a.				\$
b.				\$
c.				\$
4. TOTAL				\$

5. Use the table below to itemize cost of temporary replacement help. If more than three replacements were temporarily employed, please include a separate sheet detailing the information shown below for additional occurrences.

Temporary Help	EIN/SSN	Table 3 Reference #	Beginning Date of Service	Ending Date of Service	Cost of Temporary Help Paid
a.					\$
b.					\$
c.					\$
6. TOTAL					\$

7. Total Organ & Bone Marrow Donor Tax Credit requested (Line 4 + Line 6) \$ _____
8. Apportionment Factor – $\frac{\text{Total Compensation paid in the Commonwealth}}{\text{Total Compensation paid Everywhere}}$ divided by _____
9. **Pennsylvania Organ & Bone Marrow Donor Tax Credit (Line 7 X Line 8)** \$ _____

SIGNATURE AND VERIFICATION

Under penalties of perjury, I declare I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief it is true, correct and complete. **THIS FORM MUST BE SIGNED BY A CORPORATE OFFICER.**

SIGNATURE OF OFFICER OF COMPANY	TITLE	DATE
PRINT OFFICER’S NAME	TELEPHONE NUMBER ()	E-MAIL ADDRESS
NAME OF PREPARER	PREPARER’S ADDRESS	
TELEPHONE NUMBER ()	PREPARER’S EIN OR SSN	DATE
	CITY	STATE ZIP CODE

Department Use Only POSTMARK DATE:	
---------------------------------------	--