Massachusetts Department of Revenue

Form MDCTA

Medical Device Credit Transfer Application 2017

For calendar year 2017 or taxable year beginning **and ending**

Medical device company name | Federal Identification number | Social Security number

Mailing address

City/Town | State | Zip

Name of contact person | Phone number | E-mail address

1 Type of medical device company

○ Corporation ○ Trust ○ Partnership ○ Sole proprietorship ○ LLC ○ Other (specify)

2 Medical device credit amount eligible for transfer (amount on line 4 of Form MDCC unused by the medical device company or transferor) **2**

3 Certificate number issued by the Department of Revenue with respect to amount shown in line 2 above (from line 3 of Form MDCC) **3**

4 Amount of medical device credit in line 2 above to be transferred with this application **4**

5 Amount of financial assistance provided **5**

If the financial assistance is other than in cash, explain

6 Date(s) financial assistance provided (mm/dd/yyyy) **6**

7 Describe the Massachusetts use(s) to which the private financial assistance will be put

Name of purchasing company | Federal Identification number | Social Security number

Mailing address

City/Town | State | Zip

Declaration

I declare under the pains and penalties of perjury that to the best of my knowledge, the information contained herein is accurate and complete.

Signature | Title of authorized representative | Date

A copy of Form MDCC must be enclosed with this application. Mail to: **Massachusetts Department of Revenue, Audit Division, 200 Arlington Street, Room 4300, Chelsea, MA 02150, attn.: Credit Unit.**

On this ____ day of ____ before me, the undersigned notary public, personally appeared ____, provided to me through satisfactory evidence of identification, which was ____, to be the person whose name was signed above, and who swore or affirmed to me that the private financial assistance specified in line 5 above has been provided.

Signature of notary public | Date of expiration of commission