Maryland Income Tax Credit for Preceptors in Areas With Health Care Workforce Shortages

Application Instructions

Below are instructions for filing an application with the Maryland Income Tax Credit for Preceptors in Areas With Health Care Workforce Shortages Program. Please type your responses

There are four (4) application parts associated with the application. Only complete applications received by the stated application deadline will be reviewed.

Part 1: Completed and Submitted by the Applicant

1. **Tax Credit Information:** Provide the Tax Year for which the applicant is claiming the tax credit.

2. **Information about the Applicant:** Provide requested information.

3. **Information about the Applicant's Spouse:** If the applicant will file joint tax returns, check the box and provide the requested information.

4. **Qualification Criteria:** Provide information regarding the Program qualification criteria.

5. **Description of the Practice Site:** Provide information regarding the practice site(s) at which preceptorship rotations were conducted.

6. **Application Verification and Attestation:** Complete and sign to verify and attest to data provided.

7. **Supporting Documents:** It is essential that each of the supporting documents noted below is received by published deadlines. Data provided within each supporting document must be consistent and without contradiction in order to be accepted for review.
   (a) **Part 2**, **Proof of Student Attendance:** Completed and submitted by the applicant. Must be completed in full, documenting the name, academic program and institution of precepted students with the rotation timeframe/hours for the preceptorship
   (b) **Part 3**, **Proof of Preceptorship:** Completed **and** submitted by the academic institution of each precepted student. Form is used to validate Part 2.
   (c) **Part 4. Professional License:** Submitted by the applicant. Submit a copy of your Maryland professional license (Physician, NP, PA, CNM, CNS, CRNA, RN, or LPN).

8. **Submission:** All completed documentation must be submitted to: **mdh.preceptortaxcredit@maryland.gov** by the published deadline. Applicants are responsible for ensuring all required parts of the application are completed fully and received on-time. Only complete applications will be considered.

Maryland Income Tax Credit for Preceptors in Health Care Workforce Shortages Areas

Application for Tax Credit Certificate
Application Period: December 1 – January 5

Part 1: Applicant Information and Attestation

Please type your responses to the following:

1. Tax Credit Information

Tax Year (Indicate the tax year for which you are applying for tax credit): TY_____

2. Information about the Applicant:

(a) First Name	Middle	Last Name	
(b) Mailing Address (Street number, street, city, state, zip code)			
(c) Telephone Number	(d) Email Address	(e) Social Security Number	
(f) National Provider Number (NPI)	(g) Health Professional License Number and Issuing State	(h) Health Professional License ☐ Physician ☐ Nurse Practitioner ☐ Certified Nurse Midwife ☐ Clinical Nurse Specialist ☐ Certified Registered Nurse Anesthetist ☐ Physician Assistant ☐ Registered Nurse ☐ Licensed Practical Nurse	(i) PAs: Supervising Physician's Name

3. Information about the Applicant's Spouse:

☐ Check here, if you will file joint returns and provide information about your spouse:

(a) Spouse First Name	Middle	Spouse Last Name
(b) Spouse Social Security Number (Last 4 Digits Only): XXX-XX-		

4. Qualification Criteria

(a) Are you recognized as a preceptor by a liaison committee on medical education-accredited medical school or post-graduate medical training program, physician assistant program, or nursing education program recognized by the Maryland Board of Nursing? See Program website for approved programs.	☐ Yes	☐ No
(b) What student types did you precept this tax year/ are included in Parts 2 and 3 of this application?	☐ Medical ☐ Nurse Practitioner ☐ Physician Assistant ☐ Registered Nursing ☐ Licensed Practical Nursing	
(c-d) Did you provide community-based clinical training in family medicine, general internal medicine, or general pediatrics?	(c) ☐ Yes ☐ No (d) Specialty: _____	
(e-f) Did you act as a preceptor for a minimum of three rotations that each consisted of at least: - 100 hours of community based clinical training for **Medical and/or Physician Assistant** students? **And/Or** - 90 hours of community based clinical training for **Nurse Practitioner, Registered Nurse and/or Licensed Practical Nurse** students?	(e) Total Number of Rotations:_____ (f) Total Hours for: - Medical and Physician Assistant Students: _____ - Nurse Practitioner, Registered Nurse and Licensed Practical Nurse Students: _____	
(g-h) Did you provide community based clinical training in an area of the State identified as having a health care workforce shortage?	(g) ☐ Yes ☐ No (h) Which category(ies) describe(s) your practice location: ☐ Health professional shortage area (HPSA); ☐ Medically underserved area or population (MUA/P); ☐ Federal or state designated rural area	
(i) Were the claimed preceptorships served without compensation?	☐ Yes	☐ No

5. Description of the Practice Site

Name of Practice Site:			
Practice Address:			
Type of Practice ☐ Private Practice	☐ Community Health Clinic	☐ Hospital	☐ Other:
Name of Practice Site, Location #2, if applicable:			
Practice Address:			
Type of Practice ☐ Private Practice	☐ Community Health Clinic	☐ Hospital	☐ Other:

6. Verification and Attestation

Collection of Personal Information: In accordance with Executive Order 01.01.1983.18, the Department of Health ("MDH") advises you as follows: Certain personal information requested by the Department is necessary in determining your eligibility. Failure to disclose this information may result in the denial of one of these benefits or services. Availability of this information for public inspection is governed by the provisions of the Maryland Public Information Act, State Government Article, Sections 10-611 et seq. of the Annotated Code of Maryland. This information will be disclosed to appropriate staff of the Department and other public officials for purposes directly connected with administration on the program for which its use is intended. Such information is routinely shared with State, federal, or local government agencies. You have the right to inspect, amend, or correct personal records in accordance with the Maryland Public Information Act.

Employment Wage Data: Periodically, the Office of Labor Market Analysis and Information of the Maryland Department of Labor (DoL) , in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics ("BLS"), collects employment and waged data from you and other employers who conduct business in the State of Maryland. This information, collected on the Multiple Worksite Report (BLS3020) and the Annual Refiling Survey (BLS3023), is kept confidential and may only be used by MDH with your written consent. MDH is requesting disclosure of this information in order to evaluate the effectiveness of MDH economic development programs and their impact on your company's employment level.

Consent: I give consent to DoL to release the information that our company provides on the BLS3023 form and the BLS3020 form to MDH, solely for the purpose of evaluating the effectiveness of the MDH economic development programs and their impact on our company's employment level.

Verification and Attestation: I declare under the penalties of perjury, pursuant to Sec. 1-203 of the Tax General Article, Annotated Code of Maryland, that this application (including any accompanying forms and statements) has been examined by me, and the information contained herein, to the best of my knowledge

and belief, is true, correct, and complete. I understand that the Department may request at a later date additional information to verify the statements reported on this form, and that independent verifications of the information reported may be made.

Further, I hereby authorize the Social Security Administration, Comptroller of the Treasury, and Internal Revenue Service to release to the Department of Health any and all information concerning the income or benefits received.

_____	_____
Date	Applicant Signature
_____	_____
Phone Number	Name (Printed)
_____	_____
Email Address	Primary Practice Site Name

Whom to contact for further information, if different than applicant:

Name (Print):	**Title:**
Phone:	**Email:**

7. Supporting Documents

a. **Part 2**, **Proof of Student Attendance:** Completed and submitted by the applicant. Must be completed in full, documenting the name, academic program and institution of precepted students with the rotation time frame/hours for the preceptorship
b. **Part 3**, **Proof of Preceptorship:** Completed **and** submitted by the academic institution of each precepted student. Form is used to validate Part 2.
c. **Part 4. Professional License:** Submitted by the applicant. Submit a copy of your Maryland professional license (Physician, NP, PA, CNM, CNS, CRNA, RN, or LPN) .

8. Submission

Submit this application by published deadline, via email to:

Workforce Coordinator
Office of Population Health Improvement
Maryland Department of Health
Phone: 410-767-6123
Email: mdh.preceptortaxcredit@maryland.gov