



Georgia Department of Revenue - Motor Vehicle Division

Public Safety First Responder State and Local Title Ad Valorem Tax Exemption Application



Purpose of this Form: This form is to be used by any Public Safety First Responder who has received a major injury in the line of duty to apply for an exemption from state and local title ad valorem tax on motor vehicles.

How to submit this Form: This completed form must be submitted to your local county tag office. Please refer to our website at dor.georgia.gov to locate the address(es) for your specific County.

Special Information: For state and local tax exemption, the applicant may only exempt a maximum of \$50,000.00 in aggregate of the fair market value combined for all motor vehicles that he or she registers in this state during any three-year period.

Required Documentation: You are required to provide your award letter from the Department of Administrative Services, to be submitted with this form, confirming you are receiving payments pursuant to O.C.G.A § 45-9-85 – Payment of indemnification for death or disability.

A REGISTRANT INFORMATION								
First Responder's Full Legal Name:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 2px;">First Name</td> <td style="width: 20%; padding: 2px;">Middle Initial</td> <td style="width: 30%; padding: 2px;">Last Name</td> <td style="width: 20%; padding: 2px;">Suffix</td> </tr> </table>	First Name	Middle Initial	Last Name	Suffix			
First Name	Middle Initial	Last Name	Suffix					
Mailing Address:	<input style="width: 95%;" type="text"/>							
City:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; padding: 2px;"><input style="width: 95%;" type="text"/></td> <td style="width: 10%; padding: 2px;">State:</td> <td style="width: 10%; padding: 2px;"><input style="width: 95%;" type="text"/></td> <td style="width: 10%; padding: 2px;">ZIP Code:</td> <td style="width: 10%; padding: 2px;"><input style="width: 95%;" type="text"/></td> <td style="width: 10%; padding: 2px;">Telephone No.:</td> <td style="width: 30%; padding: 2px;"><input style="width: 95%;" type="text"/></td> </tr> </table>	<input style="width: 95%;" type="text"/>	State:	<input style="width: 95%;" type="text"/>	ZIP Code:	<input style="width: 95%;" type="text"/>	Telephone No.:	<input style="width: 95%;" type="text"/>
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Surviving Spouse's Full Legal Name: <small>(If Applicable)</small>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 2px;">First Name</td> <td style="width: 20%; padding: 2px;">Middle Initial</td> <td style="width: 30%; padding: 2px;">Last Name</td> <td style="width: 20%; padding: 2px;">Suffix</td> </tr> </table>	First Name	Middle Initial	Last Name	Suffix			
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B VEHICLE INFORMATION								
Vehicle Identification No. (VIN):	<input style="width: 100%; height: 20px;" type="text"/>							
Year:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 2px;"><input style="width: 95%;" type="text"/></td> <td style="width: 15%; padding: 2px;">Make:</td> <td style="width: 40%; padding: 2px;"><input style="width: 95%;" type="text"/></td> <td style="width: 30%; padding: 2px;">Model:</td> <td style="width: 10%; padding: 2px;"><input style="width: 95%;" type="text"/></td> </tr> </table>	<input style="width: 95%;" type="text"/>	Make:	<input style="width: 95%;" type="text"/>	Model:	<input style="width: 95%;" type="text"/>		
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C OTHER INFORMATION								
Occupation: <small>(Check One)</small>	<table style="width: 100%;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Law Enforcement Officer</td> <td style="width: 50%;"><input type="checkbox"/> Publicly Employed Emergency Medical Technician</td> </tr> <tr> <td><input type="checkbox"/> Fireman</td> <td><input type="checkbox"/> Surviving Spouse of First Responder</td> </tr> </table>	<input type="checkbox"/> Law Enforcement Officer	<input type="checkbox"/> Publicly Employed Emergency Medical Technician	<input type="checkbox"/> Fireman	<input type="checkbox"/> Surviving Spouse of First Responder			
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Medical Status: <small>(Related to Line of Duty)</small>	<table style="width: 100%;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Total Permanent Disability</td> <td style="width: 50%;"><input type="checkbox"/> Partial Permanent Disability</td> </tr> <tr> <td><input type="checkbox"/> Organic Brain Damage</td> <td><input type="checkbox"/> Deceased</td> </tr> </table>	<input type="checkbox"/> Total Permanent Disability	<input type="checkbox"/> Partial Permanent Disability	<input type="checkbox"/> Organic Brain Damage	<input type="checkbox"/> Deceased			
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<input type="checkbox"/> Organic Brain Damage	<input type="checkbox"/> Deceased							
<p>By signing this application, I as the First Responder or surviving spouse, attest to the fact that:</p> <p>(A) An injury was suffered in the course of official duties;</p> <p>(B) Said injury resulted in total permanent disability, partial permanent disability, organic brain damage or death.</p> <p>(C) No pending charges are being faced and/or there have not been any criminal convictions related to conduct in the line of duty.</p> <p>(D) State occupational license as a law enforcement officer, fireman, or emergency medical technician is not subject to pending action for suspension or revocation or said license has not been suspended or revoked due to bad conduct.</p>								
First Responder's or Surviving Spouse's Signature:	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 2px;"><input style="width: 95%;" type="text"/></td> <td style="width: 30%; padding: 2px;">Date:</td> <td style="width: 10%; padding: 2px;"><input style="width: 95%;" type="text"/></td> </tr> </table>	<input style="width: 95%;" type="text"/>	Date:	<input style="width: 95%;" type="text"/>				
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