



Massachusetts Department of Revenue
Form MDCA
Medical Device Credit Application

2016

For calendar year 2016 or taxable year beginning		and ending
Name of medical device company	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 (fill in one only):
☐ Corporation ☐ Trust ☐ Partnership ☐ Sole proprietorship ☐ LLC ☐ Other _____

2 Qualified user fees paid to U.S. Food and Drug Administration during the taxable year. ("Qualified user fees" are "user fees" as defined in TIR 06-22.) **Note:** Include only those qualified user fees related to new medical devices or to upgrades, changes or enhancements to existing medical devices, developed or manufactured in Massachusetts. A new medical device or an upgrade, change or enhancement to an existing medical device is "developed or manufactured in Massachusetts" if more than 50% of the development or manufacturing costs associated with the medical device or the upgrade, change or enhancement are incurred in Massachusetts. **2**

3 Date(s) of qualified user fee payment(s) (mm/yy/dddd) **3** _____

4 Address of Massachusetts plant or facility

5 Brief description of medical device(s) to which the above user fees relate _____

6 Percentage of development or manufacturing costs incurred in Massachusetts **6**

Note: Attach copies of all USDA Department of Health and Human Services Food and Drug Administration Medical Device User Fee Cover Sheets associated with this application.

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	Date
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Mail to: **Massachusetts Department of Revenue, Audit Division, 200 Arlington Street, Room 4300, Chelsea, MA 02150, attn.: Credit Unit.**