Massachusetts Department of Revenue

Form MDCA
Medical Device Credit Application 2019

For calendar year 2019 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

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