ANNE M. GANNON
CONSTITUTIONAL TAX COLLECTOR
Serving Palm Beach County
Serving *you.*

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PBCTC Form 49 Rev. 4/2023

PALM BEACH COUNTY LOCAL BUSINESS TAX FEE EXEMPTION REQUEST FORM

PLEASE NOTE: If your business has 100 or more employees, you are not eligible for this exemption.

All information is required to process your exemption request. First time applicants are required to complete an Application for Palm Beach County Local Business Tax Receipt Form 65 in addition to this form.

Exemption Reason (Please select one of the options below)

OPTION #1 If your business has **fewer than 100 employees**, check the reason below (F.S. 205.055):

- ☐ Honorably discharged veteran
- ☐ Spouse of honorably discharged veteran
- ☐ Un-remarried surviving spouse of honorably discharged veteran
- ☐ Low income individuals receiving public assistance (re-evaluated yearly)
- ☐ Low income individuals with a household income less than 130 percent of the federal poverty level based on the current year's federal poverty guidelines
- ☐ Spouse of a certain active duty military service member who relocated to the county pursuant to a permanent change of station order

OPTION #2 If your business **does not have more than one employee**, and the use of your **own capital does not exceed $1,000.00**, and you are a **Palm Beach County resident**, then select one of the following (F.S.205.162):

- ☐ Disabled person **(please have reverse side completed by a physician)**
- ☐ Widow with minor dependent(s)
- ☐ Person 65 years of age or older **(submit with copy of identification)**

See the back of this form for proof of RESIDENCY REQUIREMENTS.

Mail Exemption Request Form to:

Tax Collector,
Palm Beach County
P.O. Box 3353
West Palm Beach, FL 33402-3353

***Fields Marked With An Asterisk Are Required**

***Business Name/Organization/Entity:**		
***Business Address:**		
***City:**	**State:**	**ZIP Code:**
Mailing Address (if different from above):		
City:	**State:**	**ZIP Code:**
Local Business Tax Receipt # (if applicable):		
***Federal Employer Identification Number (FEIN):**		**or Social Security Number:**
***Contact Person:**		**Title/Relationship:**
***Phone:**		**Alternate Phone:**
***Email:**		

I hereby attest that I am authorized to sign on behalf of the applicant/organization or entity described above. I further attest that if granted, this exemption will only be used in the manner authorized under the provisions of Chapter 205 of the Florida Statutes.
Under penalties of perjury, I declare that I have read the foregoing exemption request and that the facts stated and attached herein are true.

Print Name

Title/Relationship

Signature

Date

4/17/23

PHYSICIAN'S CERTIFICATE FOR DISABLED PERSONS

STATE OF FLORIDA COUNTY OF _____

I,_____, hereby certify that I am a licensed practicing physician, located at _____, Florida, and I am personally acquainted with _____who is an applicant for the exemption from payment of business tax under the provisions of Chapter 205 of the Florida Statutes, and that on (MM/DD/YYYY)_____I have thoroughly examined the said applicant and found him/her to be physically disabled. The nature and extent of the applicant's disability are as follows:

Print Physician's Name

Physician's Signature

Address

City

State

Zip

Phone Number

Date

PROOF OF RESIDENCY

Please include a photocopy of one of the following for proof of residency:

- [ ] Driver License/ID Card
- [ ] Voter Registration Card