SALES TAX & LICENSING DIVISION
749 MAIN STREET
LOUISVILLE, CO 80027
www.louisvilleco.gov

EMAIL salestax@louisvilleco.gov
PHONE (303) 335-4514
FAX (303) 335-4529

CLAIM FOR REFUND

Trade (DBA) Name of Business	
Taxpayer Name Owner(s), Partner(s), or Corporation	
Corporate Business Address -Street, City, State, Zip-	
Local Mailing Address (if different) -Street, City, State, Zip-	

City of Louisville SalesTax License#		Type of Tax: ☐ Sales ☐ Use	
Date Tax Paid (MM/DD/YY)	__ __ / __ __ / __ __	**Original Amount Paid:**	
Correct Amount:		**Refund Requested * :**	
Reason for Refund Request (Explain in this space or on a separate sheet of paper if necessary).			

***All supporting documentation must be attached.**

I declare under penalty of perjury that this claim, including all attachments, is true and correct to the best of my knowledge. I further understand that the claim and documentation are subject to the provisions and penalties contained in Ordinance 1375, Series 2002 as it exists or is hereafter amended.

Taxpayer Signature _____ Date _____
(This line must be signed by an officer, partner, or owner of the firm claiming the refund)
Taxpayer Name (PRINT) _____ Phone ( )
Taxpayer Title _____

Signature of Preparer
(if other than Taxpayer) _____ Date _____

Name of Firm:	Phone ( )