EF-62-A-R05-0520-17000256-1 BOE-62-A REV. 05 (05-20)



## Richard Ford County Assessor-Recorder

255 North Forbes Street Lakeport, CA 95453 Assessor's Office Phone: 707-263-2302

Recorder's Office Phone: 707-263-2293

Lake County Courthouse

Fax: 707-263-3703

## **CERTIFICATE OF DISABILITY**

The claimant listed below has applied to transfer their property tax base to a replacement property as provided by section 69.5 of the Revenue and Taxation Code. In order to qualify for this one-time tax benefit, a licensed physician or surgeon of appropriate specialty must certify the disability of the claimant, or claimant's spouse, is both severe and permanent. The definition for a severely and permanently disabled person is, ". . . any person who has a physical disability or impairment, whether from birth or reason of accident or disease, including, but not limited to, any disability or impairment which affects sight, speech, hearing or use of any limbs and which results in a functional limitation as to employment or substantially limits one or more major life activities of that person, and which has been diagnosed as permanently affecting the person's ability to function." (Revenue and Taxation Code section 74.3)

Code section 74.3)		
I. TO BE COMPLETED BY A PHYSICIAN (please print)		
Patient's Name:	Date of disability:	
Description of patient's disability:		
Identify: (1) the specific reasons why the disability necessitates including any locational requirements, of a replacement dwelling		nd (2) the disability-related requirements
I am a licensed physician surgeon. My specialty	is:CERTIFICATION	
I certify that in my medical opinion the above named pa	tient does qualify as a disabled person	according to the definition above.
PHYSICIAN'S SIGNATURE		DATE
PHYSICIAN'S NAME (print or type)		DAYTIME PHONE NUMBER
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOU	SE OR LEGAL GUARDIAN (please pri	nt)
CLAIMANT'S NAME	SPOUSE'S NAME	
PROPERTY ADDRESS		ASSESSOR'S PARCEL NUMBER
CERTIFICATE	OF DISABILITY (check A or B)	
A: 1. The claimant or spouse must describe in their own identified in Part I (Part I must be completed by a part I)		eets the disability-related requirements
I certify (or declare) under penalty of perjury under replacement dwelling is to satisfy the identified disa		
B: I certify (or declare) under penalty of perjury under t replacement dwelling is to alleviate the financial burde	he laws of the State of California that	the primary purpose of the move to the
SIGNATURE OF CLAIMANT	DAYTIME PHONE NUMBER	DATE
SIGNATURE OF SPOUSE	DAYTIME PHONE NUMBER	DATE
SIGNAL OF SPOUSE	( )	DATE
E-MAIL ADDRESS	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	

