

CERTIFICATE OF DISABILITY

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

I. TO BE COMPLETED BY A PHYSICIAN (please print)

PHYSICIAN OR SURGEON'S NAME (print or type) DAYTIME PHONE NUMBER II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF CLAIMANT NAME OF SPOUSE OR LEGAL GUARDIAN PROPERTY ADDRESS ASSESSOR'S PARCELID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) Assessor's parcelid number A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-relater requirements identified in Part I (Part I must be completed by a physician or surgeon): AND 2. I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to replacement primary residence is to satisfy the identified disability-related requirements described in Part I. OR B: I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to replacement primary residence is to astisfy the identified disability-related requirements described in Part I. OR B: I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain:	Identify: (1) the specific reasons why the disability necessitates a move to the replacement primary residence, and (2) the disability-related requirements, including any locational requirements, of a replacement primary residence: I am a licensed	Patient's	Name:		Date of disability:				
related requirements, including any locational requirements, of a replacement primary residence: I am a licensed physician I am a licensed physician CERTIFICATION OF DISABILITY I certify that in my medical opinion, the above-named patient does qualify as a disabled person according to the definition above. SIGNATURE OF PHYSICIAN OR SURGEON PHYSICIAN OR SURGEON'S NAME (prime or type) II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF CLAIMANT PROPERTY ADDRESS ASSESSOR'S PARCEL/ID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) CERTIFICATION OF DISABILITY related requirements described in Part I (Part I must be completed by a physician or surgeor): CERTIFICATION OF perjury under the laws of the State of California that the primary purpose of the move to replacement primary residence is to satisfy the identified disability-related requirements described in Part I. OR ND 2. I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to replacement primary residence is to satisfy the identified disability-related requirements described in Part I. OR ND 2. I certify (or declare) under penalty of perjury under the laws of the State of	related requirements, including any locational requirements, of a replacement primary residence: I am a licensed physician surgeon. My specialty is: CERTIFICATION OF DISABILITY I certify that in my medical opinion, the above-named patient does qualify as a disabled person according to the definition above. SIGNATURE OF PHYSICIAN OR SURGEON PHYSICIAN OR SURGEONS NAME (print or type) DATE II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF SPOUSE OR LEGAL GUARDIAN IN. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF SPOUSE OR LEGAL GUARDIAN PROPERTY ADDRESS ASSESSOR'S PARCELID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) Claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-relate requirements identified in Part I (Part I must be completed by a physician or surgeon): AXID 2. I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to the replacement primary residence is to satisfy the identified disability-related requirements described in Part I. OR ND 2. I certify (or declare) under penalty of perjury under the financial burdens caused by the disability. Please explain: DATE OR ND 2. DATE	Descriptio	on of patient's disability:						
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