

COUNTY OF ALAMEDA PHONG LA, ASSESSOR

1221 Oak St., Rm 145 Oakland, Ca. 94612-4288 (510) 272-3787 Fax (510) 272-3803 www.acgov.org/assessor

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)

_____ Date of disability: ____

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

Patient's Name: _

Description of patient's disability:

Identify: (1) the specific reasons why the disability necessitates a move to the replacement dwelling and (2) the disability-related requirements, including any locational requirements, of a replacement dwelling:

I am a licensed physician sur

surgeon. My specialty is:

	CERTIFICATION	
I certify that in my medical opinion th	he above named patient does qualify as a disabled p	erson according to the definition above.
PHYSICIAN'S SIGNATURE	DATE	
PHYSICIAN'S NAME (print or type)		
II. TO BE COMPLETED BY CLAIMANT, C	LAIMANT'S SPOUSE OR LEGAL GUARDIAN (ple	ase print)
CLAIMANT'S NAME	SPOUSE'S NAME	
PROPERTY ADDRESS	ADDRESS ASSESSOR'S PARCEL NUMBER	
	CERTIFICATE OF DISABILITY (check A or B)	
A: 1. The claimant or spouse must de identified in Part I (Part I must)	escribe in their own words how the replacement dwe be completed by a physician):	ling meets the disability-related requirements
	AND	
2. I certify (or declare) under pen	alty of perjury under the laws of the State of Califor	nia that the primary purpose of the move to th

replacement dwelling 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 the
	replacement dwelling is to alleviate the financial burdens caused by the disability.

SIGNATURE OF CLAIMANT	DAYTIME PHONE NUMBER	DATE
	()	
SIGNATURE OF SPOUSE	DAYTIME PHONE NUMBER	DATE
	()	
E-MAIL ADDRESS		

