EF-19-DC-R02-0522-03000287-1
BOE-19-DC (P1) REV. 02 (05-22)

**James B Rooney**
**Assessor of Amador County**
810 Court Street
Jackson, CA 95642
PH: (209) 223-6351
FAX: (209) 223-6721

## 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)*

Patient's Name: _____ Date of disability: _____

Description of patient's disability: _____

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 ☐ 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 ▶ | DATE |
|---|---|
| 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 PARCEL/ID NUMBER |

**CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS** *(check A or B)*

☐ A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-related 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 the 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 the replacement primary residence is **to alleviate the financial burdens** caused by the disability.*

Please explain: _____

| SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN ▶ | PRINTED NAME |
|---|---|
| DAYTIME PHONE NUMBER ( ) | DATE |
| EMAIL ADDRESS | |

**THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION**

EF-19-DC-R02-0522-03000287