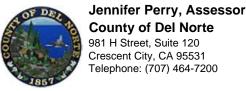
CERTIFICATE OF DISABILITY

The claimant listed below has applied to transfer his or her 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)

Patient's Name:	Date of disability:	
Description of patient's disability:		
Identify: (1) the specific reasons why the disability necessitates a movincluding any locational requirements, of a replacement dwelling:	ve to the replacement dwelling	and (2) the disability-related requirements
I am a licensedphysiciansurgeon. My specialty is:		
	FICATION	and the second
I certify that in my medical opinion the above named patient de PHYSICIAN'S SIGNATURE	bes quality as a disabled perso	DATE
PHYSICIAN'S NAME (print or type)		DAYTIME PHONE NUMBER
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR	LEGAL GUARDIAN (please p	print)
CLAIMANT'S NAME	SPOUSE'S NAME	
PROPERTY ADDRESS		ASSESSOR'S PARCEL NUMBER
CERTIFICATE OF D	SABILITY (check A or B)	
A: 1. The claimant or spouse must describe in his or her own we identified in Part I (Part I must be completed by a physici	ords how the replacement dwelli	ing meets the disability-related requirements
AN 2. I certify (or declare) under penalty of perjury under the la replacement dwelling is to satisfy the identified disability-i O B: I certify (or declare) under penalty of perjury under the law	aws of the State of California th related requirements described R	in Part I.
replacement dwelling is to alleviate the financial burdens cau	ised by the disability.	
SIGNATURE OF CLAIMANT	DAYTIME PHONE NUMBER	DATE
SIGNATURE OF SPOUSE	() DAYTIME PHONE NUMBER	R DATE
	()	
E-MAIL ADDRESS		1

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION



County of Del Norte 981 H Street, Suite 120 Crescent City, CA 95531 Telephone: (707) 464-7200

