EF-19-DC-R02-0522-17000305-1 BOE-19-DC (P1) REV. 02 (05-22)



## Richard Ford County Assessor-Recorder

Lake County Courthouse 255 North Forbes Street Lakeport, CA 95453 Assessor's Office Phone: 70

Assessor's Office Phone: 707-263-2302 Recorder's Office Phone: 707-263-2293

Fax: 707-263-3703

## **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 PHY	'SICIAN (please print)					
Patient's Name:	S Name: Date of disa			sability:		
Description of patient's disability:						
Identify: (1) the specific reasons w related requirements, including any				residenc	e, and (2) the disability-	
I am a licensed  physician	surgeon. My specialty is:					
Loortify that in my modical o	CERTIFICATIO		·	ocordina	to the definition above	
I certify that in my medical opinion, the above-named patient does qualify as a disabled person according to the surgeon signature of Physician or Surgeon				ccording	DATE DATE	
PHYSICIAN OR SURGEON'S NAME (print or type)					DAYTIME PHONE NUMBER	
II. TO BE COMPLETED BY CLAIM	MANT, CLAIMANT'S SPOUSE, O	R LEGAL	GUARDIAN (please prin	t)		
NAME OF CLAIMANT NAME OF SPOUSE OR LEGAL GUARDIA				AN		
PROPERTY ADDRESS			ASSESSOR'S PARCEL/ID NUMBER			
CE	RTIFICATION OF DISABILITY-R	ELATED F	REQUIREMENTS (check	A or B)		
A: 1. The claimant, spouse requirements identified	, or legal guardian must describ I in Part I <i>(Part I <b>must</b> be complete</i>			residend	ce meets the disability-related	
		ND	Otata of Oalifamia that	46		
	nder penalty of perjury under the la esidence is <b>to satisfy the identific</b> O					
B: I certify (or declare) undereplacement primary resid	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 <b>to alleviate the financial burdens</b> caused by the disability.					
Please explain:						
SIGNATURE OF CLAIMANT, SPOUSE, OR LEGA	ıl Guardian		PRINTED NAME			
DAYTIME PHONE NUMBER  ( )					DATE	
EMAIL ADDRESS					1	

