EF-62-A-R04-0810-17000727-1
BOE-62-A REV. 04 (08-10)

Richard Ford
County Assessor-Recorder
Lake County Courthouse
255 North Forbes Street
Lakeport, CA 95453
Assessor's Office Phone: 707-263-2302
Recorder's Office Phone: 707-263-2293
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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)

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 dwelling and (2) the disability-related requirements, including any locational requirements, of a replacement dwelling:

I am a licensed ☐ physician ☐ surgeon. My specialty is: _____

CERTIFICATION

I certify that in my medical opinion the above named patient does qualify as a disabled person according to the definition above.

PHYSICIAN'S SIGNATURE ▶	DATE
PHYSICIAN'S NAME *(print or type)*	DAYTIME PHONE NUMBER ( )

II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR LEGAL GUARDIAN *(please print)*

CLAIMANT'S NAME	SPOUSE'S NAME
PROPERTY ADDRESS	ASSESSOR'S PARCEL NUMBER

CERTIFICATE OF DISABILITY *(check A or B)*

☐ A: 1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related requirements identified in Part I *(Part I **must** be completed by a physician)*:

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 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

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION

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