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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, or claimant's spouse, is severe. The definition of a severely disabled person is any person having a great degree of impairment or who is greatly limited by a physical, mental, cognitive, or developmental condition.

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

CERTIFICATE 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

