EF-19-DC-R02-0522-23000263-1 BOE-19-DC (P1) REV. 02 (05-22)



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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 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: | s Name: Date of disability: | | | |
| Description of patient's disability: | | | | |
| Identify: (1) the specific reasons why the disability necessitates a related requirements, including any locational requirements, of a repla | | | residenc | e, and (2) the disability- |
| I am a licensed physician surgeon. My specialty is: | | | | |
| CERTIFICATIO | | | | |
| I certify that in my medical opinion, the above-named patient o | does qualit | y as a disabled person a | ccording | |
| 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, O | | | - | |
| NAME OF CLAIMANT | NAME C | F SPOUSE OR LEGAL GUARDI | AN | |
| PROPERTY ADDRESS | | ASSESSOR'S PARCEL/ID NUMBER | | |
| CERTIFICATION OF DISABILITY-R | ELATED I | REQUIREMENTS (check | A or B) | |
| A: 1. The claimant, spouse, or legal guardian must describe requirements identified in Part I (Part I must be complete) | | | residenc | ce meets the disability-relate |
| Al | ND | | | |
| I certify (or declare) under penalty of perjury under the l replacement primary residence is to satisfy the identifie | | | | |
| B: I certify (or declare) under penalty of perjury under the law replacement primary residence is to alleviate the financial | | State of California that to caused by the disability. | he prima | ry purpose of the move to th |
| Please explain: | | | | |
| SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN | | PRINTED NAME | | |
| DAYTIME PHONE NUMBER () EMAIL ADDRESS | | 1 | | DATE |

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION

