EF-62-A-R04-0810-27000756-1 BOE-62-A REV. 04 (08-10)

## **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)

## **Xochitl Marina Camacho Monterey County Assessor**

P. O. Box 570 Salinas, CA 93902-0570 Phone: (831) 755-5035 Fax: (831) 755-5435 assessor@co.monterey.ca.us

TO BE COMPLETED BY A PHYSICIAN (places print)		
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 including any locational requirements, of a replacement dwelling:	to the replacement dwelling a	and (2) the disability-related requirements
I am a licensed physician surgeon. My specialty is:	ICATION	
I certify that in my medical opinion the above named patient doe		a according to the definition above
PHYSICIAN'S SIGNATURE	s quality as a disabled person	DATE DATE
PHYSICIAN'S NAME (print or type)		DAYTIME PHONE NUMBER
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR L	EGAL GUARDIAN (please pr	rint)
CLAIMANT'S NAME	SPOUSE'S NAME	
PROPERTY ADDRESS		ASSESSOR'S PARCEL NUMBER
CERTIFICATE OF DISA	ABILITY (check A or B)	
A: 1. The claimant or spouse must describe in his or her own word identified in Part I (Part I must be completed by a physician	ds how the replacement dwellin	ng meets the disability-related requirement
AND  2. I certify (or declare) under penalty of perjury under the law replacement dwelling is to satisfy the identified disability-rel	s of the State of California tha	
B: I certify (or declare) under penalty of perjury under the laws replacement dwelling is to alleviate the financial burdens cause		t the primary purpose of the move to th
SIGNATURE OF CLAIMANT	DAYTIME PHONE NUMBER	DATE
SIGNATURE OF SPOUSE	DAYTIME PHONE NUMBER	DATE
<b>&gt;</b>	( )	52
F MAIL ADDDESO		

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION

