



Josie Gonzales

Assessor-Recorder-County Clerk

San Bernardino County  
 222 W. Hospitality Lane, 4th Floor  
 San Bernardino, CA 92415-0311  
 arc.sbcounty.gov  
 909-387-8307 or 1-877-885-7654

**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: \_\_\_\_\_ 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

**CERTIFICATION 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: (1) the primary purpose of the move to the replacement primary residence is to satisfy the identified disability-related requirements described in Part I; and (2) the foregoing, and all information herein, including any accompanying statements or materials, is true, correct, and complete to the best of my knowledge and belief.*

**OR**

- ☐ B. *I certify (or declare) under penalty of perjury under the laws of the State of California that: (1) the primary purpose of the move to the replacement primary residence is to alleviate the financial burdens caused by the disability; and (2) the foregoing, and all information herein, including any accompanying statements or materials, is true, correct, and complete to the best of my knowledge and belief.*

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**