



**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

BOE-62-A REV. 06 (05-25)

**CERTIFICATE OF DISABILITY**

The claimant listed below has applied to transfer their 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<br>▶       | DATE                        |
| PHYSICIAN'S NAME (print or type) | DAYTIME PHONE NUMBER<br>( ) |

**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 their 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: (1) the primary purpose of the move to the replacement dwelling 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.

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 dwelling 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.

|                            |                             |      |
|----------------------------|-----------------------------|------|
| SIGNATURE OF CLAIMANT<br>▶ | DAYTIME PHONE NUMBER<br>( ) | DATE |
| SIGNATURE OF SPOUSE<br>▶   | DAYTIME PHONE NUMBER<br>( ) | DATE |
| E-MAIL ADDRESS             |                             |      |

**THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION**

