

COUNTY OF ALAMEDA PHONG LA, ASSESSOR

1221 Oak St., Rm 145 Oakland, Ca. 94612-4288 (510) 272-3787 Fax (510) 272-3803 www.acgov.org/assessor

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)

Description of patient's disability:	atient's Name: Date of disability:			
related requirements, including any locational requirements, of a replacement primary residence:	Description of patient's disability:			
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 PHYSICIAN OR SURGEONS NAME (print or type) II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF SPOUSE OR LEGAL GUARDIAN PROPERTY ADDRESS CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCELID NUMBER AND I. To be claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disabil requirements identified in Part I (Part I must be completed by a physician or surgeon): AND I. I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the m replacement primary residence is to satisfy the identified disability-related requirements described in Part I. B: I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the m replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain: SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME DATE				lence, and (2) the disability-
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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 SPOUSE OR LEGAL GUARDIAN NAME OF CLAIMANT NAME OF SPOUSE OR LEGAL GUARDIAN ASSESSOR'S PARCELID NUMBER PROPERTY ADDRESS ASSESSOR'S PARCELID NUMBER ASSESSOR'S PARCELID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCELID NUMBER A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disabilit 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 m replacement primary residence is to satisfy the identified disability-related requirements described in Part I. OR OR B: I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the m replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain:	CERTIF	ICATION OF DISABILIT	Y	
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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) CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCEL/ID NUMBER AND 2. I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the m 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 m 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 ()	SIGNATURE OF PHYSICIAN OR SURGEON			DATE
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 I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the mereplacement primary residence is to satisfy the identified disability-related requirements described in Part I. B: I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the mereplacement primary residence is to alleviate the financial burdens caused by the disability. Please explain: SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN DAYTIME PHONE NUMBER DATE 				dence meets the disability-rela
DAYTIME PHONE NUMBER () DATE	 replacement primary residence is to satisfy the id B: I certify (or declare) under penalty of perjury under replacement primary residence is to alleviate the final 	er the laws of the State c lentified disability-relat OR	ed requirements des	scribed in Part I.
	SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN	PRINTEL	D NAME	
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THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION			BLIC INSPECTIO	N