

## 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-
I certify that in my medical opinion, the above-named patient does qualify as a disabled person according to the definition abor SIGNATURE OF PHYSICIAN OR SURGEON PHYSICIAN OR SURGEON'S 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) A: 1. The 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 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: 	I am a licensedphysiciansurgeon. My specialty	/ is:		
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	
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)       DAME OF SPOUSE OR LEGAL GUARDIAN         NAME OF CLAIMANT       NAME OF SPOUSE OR LEGAL GUARDIAN         PROPERTY ADDRESS       ASSESSOR'S PARCELID NUMBER         CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B)       Assessor's parcelid number of 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       1. Certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the more placement 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 more placement primary residence is to alleviate the financial burdens caused by the disability.         Please explain:	I certify that in my medical opinion, the above-named pa	atient does qualify as a d	lisabled person accord	ding to the definition above.
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
NAME OF SPOUSE OR LEGAL GUARDIAN         PROPERTY ADDRESS         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 disabil 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         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         PROME PHONE NUMBER         ()	PHYSICIAN OR SURGEON'S NAME (print or type)			DAYTIME PHONE NUMBER
PROPERTY ADDRESS	II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOU	ISE, OR LEGAL GUARD	DIAN (please print)	
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 disabil 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.  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 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  DATE  DATE	NAME OF CLAIMANT	NAME OF SPOUS	E OR LEGAL GUARDIAN	
A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability requirements identified in Part I ( <i>Part I must be completed by a physician or surgeon</i> ):   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 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   ()	PROPERTY ADDRESS		ASS	ESSOR'S PARCEL/ID NUMBER
A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disabilit requirements identified in Part I ( <i>Part I must be completed by a physician or surgeon</i> ):   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 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   ()	CERTIFICATION OF DISABIL	ITY-RELATED REQUIR	EMENTS (check A or	<sup>-</sup> В)
<ol> <li>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.</li> <li>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.</li> <li>Please explain:</li> <li>SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN</li> <li>DAYTIME PHONE NUMBER</li> <li>DATE</li> </ol>				dence meets the disability-rela
DAYTIME PHONE NUMBER ( ) DATE	<ul> <li>replacement primary residence is to satisfy the id</li> <li>B: I certify (or declare) under penalty of perjury under replacement primary residence is to alleviate the final</li> </ul>	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	
( ) EMAIL ADDRESS	DAYTIME PHONE NUMBER			DATE
EMAIL ADDRESS	( )			
	EMAIL ADDRESS			
THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION			BLIC INSPECTIO	N