EF-62-A-R04-0810-32000512-1 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)



## Cynthia L. Froggatt Plumas County Assessor

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CindieFroggatt@countyofplumas.com

Patient's Name: Date of disability:	I. TO BE COMPLETED BY A PHYSICIAN (please print)			
Identify: (1) the specific reasons why the disability necessitates a move to the replacement dwelling and (2) the disability-related requiren including any locational requirements, of a replacement dwelling:    A certify that in my medical opinion the above named patient does qualify as a disabled person according to the definition above.	Patient's Name:	Date of disability:		
I am a licensed	Description of patient's disability:			
Certify that in my medical opinion the above named patient does qualify as a disabled person according to the definition above.   DATE		to the replacement dwelling and	d (2) the (	disability-related requirements
Certify that in my medical opinion the above named patient does qualify as a disabled person according to the definition above.    PHYSICIAN'S SIGNATURE		IOATION.		
PHYSICIAN'S NAME (print or type)  II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR LEGAL GUARDIAN (please print)  CLAIMANT'S NAME  PROPERTY ADDRESS  ASSESSOR'S PARCEL NUMBER  CERTIFICATE OF DISABILITY (check A or B)  ASSESSOR'S PARCEL NUMBER  CERTIFICATE OF DISABILITY (check A or B)  AND  1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related requirer 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 the primary purpose of the move replacement dwelling 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 move replacement dwelling is to alleviate the financial burdens caused by the disability.  SIGNATURE OF CLAIMANT  DAYTIME PHONE NUMBER  DATE				
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR LEGAL GUARDIAN (please print)  CLAIMANT'S NAME  SPOUSE'S NAME  CERTIFICATE OF DISABILITY (check A or B)  ARROW A: 1. The claimant or spouse must describe in his or her own words how the replacement dwelling meets the disability-related required 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 the primary purpose of the move of the primary purpose of the move of the completed by a physician in the state of California that the primary purpose of the move of the complete in the c		es quality as a disabled person a	ccoraing i	
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			he primai	y purpose of the move to the
	SIGNATURE OF CLAIMANT	DAYTIME PHONE NUMBER		DATE
SIGNATURE OF SPOUSE  DAYTIME PHONE NUMBER  ( )  E-MAIL ADDRESS	SIGNATURE OF SPOUSE	DAYTIME PHONE NUMBER ( )		DATE

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION

