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)

Patient's Name:	Date of disability:	
Description of patient's disability:		
Identify: (1) the specific reasons why the disability necessita including any locational requirements, of a replacement dwe		g and (2) the disability-related requirements
I am a licensed 🔄 physician 🔄 surgeon. My speci		
I certify that in my medical opinion the above named PHYSICIAN'S SIGNATURE	i patient does quainy as a disabled pers	DATE
PHYSICIAN'S NAME (print or type)		DAYTIME PHONE NUMBER
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SP	OUSE OR LEGAL GUARDIAN (please	print)
CLAIMANT'S NAME	SPOUSE'S NAME	
PROPERTY ADDRESS		ASSESSOR'S PARCEL NUMBER
CERTIFIC	ATE OF DISABILITY (check A or B)	
A: 1. The claimant or spouse must describe in his or his or his dentified in Part I (Part I must be completed by		lling meets the disability-related requirements
 I certify (or declare) under penalty of perjury u replacement dwelling is to satisfy the identified 	disability-related requirements describe	
B: I certify (or declare) under penalty of perjury und replacement dwelling is to alleviate the financial but	OR ler the laws of the State of California th irdens caused by the disability.	hat the primary purpose of the move to the
	DAYTIME PHONE NUMBE	ER DATE
SIGNATURE OF SPOUSE	DAYTIME PHONE NUMBE	ER DATE
F		

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION





James B Rooney Assessor of Amador County 810 Court Street Jackson, CA 95642 PH: (209) 223-6351 FAX: (209) 223-6721