## **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)

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 movincluding any locational requirements, of a replacement dwelling:	ve to the replacement dwelling an	d (2) the disability-related requirements,
I am a licensedphysiciansurgeon. My specialty is:		
CERTI	FICATION	
I certify that in my medical opinion the above named patient do	pes qualify as a disabled person a	
PHYSICIAN'S SIGNATURE		DATE
PHYSICIAN'S NAME (print or type)		DAYTIME PHONE NUMBER
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR	LEGAL GUARDIAN (please prin	t)
CLAIMANT'S NAME	SPOUSE'S NAME	
PROPERTY ADDRESS		ASSESSOR'S PARCEL NUMBER
CERTIFICATE OF DI	SABILITY (check A or B)	
<ul> <li>A: 1. The claimant or spouse must describe in his or her own wo identified in Part I (Part I must be completed by a physicial</li> </ul>		meets the disability-related requirements
<b>AN</b> 2. I certify (or declare) under penalty of perjury under the la replacement dwelling is to satisfy the identified disability-r	aws of the State of California that	
OF B: I certify (or declare) under penalty of perjury under the law replacement dwelling is to alleviate the financial burdens cau	<b>R</b> is of the State of California that i	
SIGNATURE OF CLAIMANT	DAYTIME PHONE NUMBER	DATE
	( )	
SIGNATURE OF SPOUSE	DAYTIME PHONE NUMBER	DATE
E-MAIL ADDRESS		



County of Inyo Dave Stottlemyre, Assessor PO Box J Independence, CA 93526 760 878-0302 Phone inyoassessor@inyocounty.us

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION

