EF-19-DC-R02-0522-17000193-1 BOE-19-DC (P1) REV. 02 (05-22)



Richard Ford County Assessor-Recorder

Lake County Courthouse 255 North Forbes Street Lakeport, CA 95453 Assessor's Office Phone: 707-

Assessor's Office Phone: 707-263-2302 Recorder's Office Phone: 707-263-2293

Fax: 707-263-3703

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)					
Patient's Name:	Name: Date of disability:				
Description of patient's disability:					
Identify: (1) the specific reasons why the disability necessitates related requirements, including any locational requirements, of a			residence	e, and (2) the disability-	
I am a licensed physician surgeon. My specialty is					
	ATION OF DISA		ooordina	to the definition chave	
I certify that in my medical opinion, the above-named patient does qualify as a disabled person according SIGNATURE OF PHYSICIAN OR SURGEON				DATE DATE	
PHYSICIAN OR SURGEON'S NAME (print or type)				DAYTIME PHONE NUMBER	
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE	E, OR LEGAL G	UARDIAN (please prin	t)		
NAME OF CLAIMANT NAME OF SPOUSE OR LEGAL GUARDIA			AN		
PROPERTY ADDRESS			ASSESSOR'S PARCEL/ID NUMBER		
CERTIFICATION OF DISABILIT	Y-RELATED RE	EQUIREMENTS (check	A or B)		
A: 1. The claimant, spouse, or legal guardian must de requirements identified in Part I (Part I must be com			residenc	e meets the disability-related	
I certify (or declare) under penalty of perjury under the replacement primary residence is to satisfy the idea.	ntified disability	State of California that t	the prima s describe	ary purpose of the move to the	
B: I certify (or declare) under penalty of perjury under the replacement primary residence is to alleviate the finan	OR e laws of the St ocial burdens ca	ate of California that the subsection of the contract that the disability.	ne primai	ry purpose of the move to the	
Please explain:					
SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN		PRINTED NAME			
DAYTIME PHONE NUMBER () EMAIL ADDRESS	1			DATE	