EF-62-A-R04-0810-17000609-1 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)



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

| 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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| | 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

