

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)

EE-19-DC-R02-0522-23

Description of patient's disability:	Patient's	Name:		Date of disability:				
Prevente of the state of California that the primary residence move to the replacement primary residence move to the replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain: Prevents Colument IS NOT SUBJECT TO PUBLIC INSPECTION Please explain: Prevents Colument IS NOT SUBJECT TO PUBLIC INSPECTION	Descript	ion of patient's disability:						
CERTIFICATION OF DISABILITY I certify that in my medical opinion, the above-named patient does qualify as a disabled person according to the definition above. SIGNATURE OF PHYSICIAN OR SURGEON PHYSICIAN OR SURGEON'S NAME (pent or type) NAME OF PHYSICIAN OR SURGEON'S NAME (pent or type) NAME OF SPOUSE OR LEGAL GUARDIAN (please print) NAME OF SPOUSE OR LEGAL GUARDIAN (please print) NAME OF SPOUSE OR LEGAL GUARDIAN PROPERTY ADDRESS ASSESSOR'S PARCELVID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCELVID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCELVID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCELVID NUMBER CERTIFICATION OF DISABILITY related requirements describe how the replacement primary residence meets the disability-related requirements identified in Part I (Part I must be completed by a physician or surgeon): ND 2. I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to th replacement primary residence is to satisfy the identified disability-related requirements described in Part I. R Please explain: SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME DATE DATE SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME DATE DATE SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME DATE DATE SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME SIGNATURE OF CLAIMANT, SPOUSE, OR LEGA						residence, a	and (2) the disability-	
I certify that in my medical opinion, the above-named patient does qualify as a disabled person according to the definition above. INTRATURE OF PHYSICIAN OR SURGEON PHYSICIAN OR SURGEON'S NAME (pinit or type) II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF CLAIMANT INTO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF SPOUSE OR LEGAL GUARDIAN PROPERTY ADDRESS CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) Assessor's PARCEL/ID NUMBER CERTIFICATION OF DISABILITY and the completed by a physician or surgeon): NAME 2. I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to the replacement primary residence is to satisfy the identified disability-related requirements described in Part I. B: I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to the replacement primary residence is to adieviate the financial burdens caused by the disability. Please explain: SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED PHONE NUMBER DATE NAME NAME NAME NAME NAME NAME NAME N	l am a lic	censed physician	surgeon. My specialty is					
SIGNATURE OF PHYSICIAN OR SURGEON PHYSICIAN OR SURGEON'S NAME (print or bpe) II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF SPOUSE OR LEGAL GUARDIAN PROPERTY ADDRESS CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-relate requirements identified in Part I (Part I must be completed by a physician or surgeon): 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 to th replacement primary residence is to satisfy the identified disability-related requirements described in Part I. B: I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to th replacement primary residence is to affeviate the financial burdens caused by the disability. Please explain: SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED PHONE NUMBER DATE SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED PHONE NUMBER DATE SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED PHONE NUMBER DATE DATE DATE DATE THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION			CERTIFIC	ATION OF DI	SABILITY			
PHYSICIAN OR SURGEON'S NAME (print or type) DayTIME PHONE NUMBER DayTIME PHONE NUMBER DayTIME PHONE NUMBER DayTIME OF CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF SPOUSE OR LEGAL GUARDIAN PROPERTY ADDRESS ASSESSOR'S PARCEL/ID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCEL/ID NUMBER ASSESSOR'S PARCEL/ID PUBLIC INSPECTION ASSESSOR'S PARCEL/ID PUBLIC INSPECTION	1	certify that in my medical o	pinion, the above-named patie	ent does quali	fy as a disabled person a	according to	the definition above.	
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF CLAIMANT NAME OF CLAIMANT NAME OF SPOUSE OR LEGAL GUARDIAN PROPERTY ADDRESS ASSESSOR'S PARCELIID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCELIID NUMBER ASSESSOR'S PARCELINN ASSESSOR'S PARCELINN'S POUSE, OR LEGAL GUARDIAN ASSESSOR'S PARCELINN ASSESSOR'S PARCELINN'S POUSE, OR LEGAL GUARDIAN	SIGNATUR	E OF PHYSICIAN OR SURGEON			DATE			
NAME OF SPOUSE OR LEGAL GUARDIAN ASSESSOR'S PARCEL/ID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCEL/ID NUMBER ASSESSOR'S PARCEL/ID NUMBER ASSESSOR'S PARCEL/ID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCEL/ID NUMBER ASSESSOR'S PARCEL/ID NUMBER NND AND I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to th replacement primary residence is to satisfy the identified disability-related requirements described in Part I. NR B: I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to th replacement primary residence is to alleviate the financial burdens caused by the disability. Hease explain: NR NR PHONE NUMBER DATIME PHONE NUMBER THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION	PHYSICIAN	N OR SURGEON'S NAME (print or ty	oe)			DAYTIME PHONE NUMBER		
PROPERTY ADDRESS	II. TO B	E COMPLETED BY CLAIN	IANT, CLAIMANT'S SPOUSE	E, OR LEGAL	GUARDIAN (please pri	nt)	,	
CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-relate requirements identified in Part I (Part I must be completed by a physician or surgeon): AXD 2. I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to the replacement primary residence is to satisfy the identified disability-related requirements described in Part I. B: I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to the replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain: SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION	NAME OF (CLAIMANT		NAME	NAME OF SPOUSE OR LEGAL GUARDIAN			
A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-relater requirements identified in Part I (<i>Part I must be completed by a physician or surgeon</i>): 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 to the replacement primary residence 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 to the replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain: DATIME PHONE NUMBER DATIME PHONE NUMBER DATE THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION	PROPERTY	YADDRESS				ASSESSOR'S PARCEL/ID NUMBER		
A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-relater requirements identified in Part I (<i>Part I must be completed by a physician or surgeon</i>): 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 to the replacement primary residence 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 to the replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain: DATIME PHONE NUMBER DATIME PHONE NUMBER DATE THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION		CE	RTIFICATION OF DISABILIT	Y-RELATED	REQUIREMENTS (chec	k A or B)		
2. I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to the replacement primary residence 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 to the replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain: DayTime PHONE NUMBER () EMAIL ADDRESS THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION	A:					residence	meets the disability-related	
DAYTIME PHONE NUMBER () EMAIL ADDRESS THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION	В:	replacement primary re I certify (or declare) unde replacement primary resid	esidence is to satisfy the ider	the laws of the ntified disabil OR	ity-related requirement	ts described	in Part I.	
DAYTIME PHONE NUMBER () EMAIL ADDRESS THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION								
() EMAIL ADDRESS THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION		E OF CLAIMANT, SPOUSE, OR LEGA	L GUARDIAN	PRINTED NAME				
THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION	DAYTIME P	HONE NUMBER)				DA	ΤΕ	
	EMAIL ADD	RESS						
		T	HIS DOCUMENT IS NOT	SUBJECT	TO PUBLIC INSPEC	TION		