## **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 move including any locational requirements, of a replacement dwelling:              | to the replacement dwelling and      | I (2) the disability-related requirements         |
|  |                                      |   |
| I am a licensedphysiciansurgeon. My specialty is:  |                                      |   |
|  | ICATION                              |   |
| I certify that in my medical opinion the above named patient does qualify as a disabled person according to the definition abov<br>PHYSICIAN'S SIGNATURE |                                      |   |
|  |                                      | 0   |
| PHYSICIAN'S NAME (print or type)   |                                      | DAYTIME PHONE NUMBER                              |
| II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR L  | EGAL GUARDIAN (please print)         | )   |
| CLAIMANT'S NAME  | SPOUSE'S NAME                        |   |
| PROPERTY ADDRESS   |                                      | ASSESSOR'S PARCEL NUMBER                          |
| CERTIFICATE OF DIS   | ABILITY (check A or B)               | I   |
| A: 1. The claimant or spouse must describe in his or her own word identified in Part I (Part I must be completed by a physician                          |                                      | neets the disability-related requirements         |
|  |                                      |   |
| AND<br>2. I certify (or declare) under penalty of perjury under the law<br>replacement dwelling is to satisfy the identified disability-re<br>OR         | vs of the State of California that t | the primary purpose of the move to the<br>Part I. |
| B: I certify (or declare) under penalty of perjury under the laws replacement dwelling is to alleviate the financial burdens caus                        |                                      | ne primary purpose of the move to the             |
| SIGNATURE OF CLAIMANT  | DAYTIME PHONE NUMBER                 | DATE  |
|  | ( )                                  |   |
| SIGNATURE OF SPOUSE  | DAYTIME PHONE NUMBER                 | DATE  |
| E-MAIL ADDRESS   | ( )                                  |   |
|  |                                      |   |

## THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION





Rolf D. Kleinhans Nevada County Assessor 950 Maidu Avenue

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