EF-62-A-R04-0810-33000516-1 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)



Peter Aldana Assessor-County Clerk-Recorder

County of Riverside PO Box 751 Riverside, CA 92502-0751 Phone: (951) 955-6200 https://www.rivcoacr.org/

| 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 ar | nd (2) the disability-related requirements | |
| I am a licensed physician surgeon. My specialty is: | CATION | | |
| I certify that in my medical opinion the above named patient doe | | according to the definition above | |
| PHYSICIAN'S SIGNATURE | s quality as a disabled person o | DATE DATE | |
| PHYSICIAN'S NAME (print or type) | | DAYTIME PHONE NUMBER | |
| II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR L | EGAL GUARDIAN (please prii | int) | |
| CLAIMANT'S NAME | SPOUSE'S NAME | | |
| PROPERTY ADDRESS | | ASSESSOR'S PARCEL NUMBER | |
| CERTIFICATE OF DISA | ABILITY (check A or B) | | |
| 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 | Is how the replacement dwelling | g meets the disability-related requirement | |
| AND | | 446 | |
| I certify (or declare) under penalty of perjury under the law replacement dwelling is to satisfy the identified disability-rel. OR | | | |
| B: I certify (or declare) under penalty of perjury under the laws replacement dwelling is to alleviate the financial burdens cause | | the primary purpose of the move to th | |
| SIGNATURE OF CLAIMANT | DAYTIME PHONE NUMBER | DATE | |
| SIGNATURE OF SPOUSE | DAYTIME PHONE NUMBER () | DATE | |

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION

