

MARK CHURCH Assessor - County Clerk - Recorder 555 County Center Redwood City, CA 94063 P 650.363.4500 F 650.599.7435 email: assessor@smcacre.gov web: www.smcacre.gov

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-R02-0522-410003

DAYTIME PHONE NUMBER () DATE	atient's Name:		Date of disability:		
Prevented requirements, including any locational requirements, of a replacement primary residence:	Description 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 NAME (print or type) II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF SPOUSE OR LEGAL GUARDIAN PROPERTY ADDRESS ASSESSOR'S PARCELID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) AND CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) 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. 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 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 satisfy the identified disability-related requirements described in Part I. CRATINE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PHONE NUMBER SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PHYSICIAN PHONE NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER NUMBER				residence, and (2) the disability-	
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SIGNATURE OF PHYSICIAN OR SURGEON DATE PHYSICIAN OR SURGEON'S NAME (print or type) DATE II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF SPOUSE OR LEGAL GUARDIAN (please print) NAME OF CLAIMANT NAME OF SPOUSE OR LEGAL GUARDIAN (please print) PROPERTY ADDRESS ASSESSOR'S PARCEL/ID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCEL/ID NUMBER A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-relat 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 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:		CERTIFICATION	N OF DISABILITY		
PHYSICIAN OR SURGEON'S NAME (print or type) DAYTIME PHONE NUMBER III. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF CLAIMANT 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 A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-relative requirements identified in Part 1 (Part 1 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 the replacement primary residence is to satisfy the identified disability-related requirements described in Part 1. OR R 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:	I certify that in my medical opin	ion, the above-named patient do	es qualify as a disabled person a	ccording to the definition above.	
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EMAIL ADDRESS	DAYTIME PHONE NUMBER			DATE	
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THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION			JECT TO PUBLIC INSPEC	TION	