ERTIFICATE OF DISABILITY www.scassessor.org The claimant is debots has applied to transfer their property tax base to a replacement primary residence. In order to qualify for a base to a replacement primary residence is a servere and permenterity disable person is, any person who has a physical disability or impairment, whether more implify a cluimant is servere and permeanity disable person is, any person who has a physical disability or impairment, whether more implify a cluimant is servere and permeanity disability or impairment, whether more implify and the abase of that person, and that has been diagnosed as permanenty discripting the persons I TO BE COMPLETED BY A PHYSICIAN (please print) Patient's Name:	9-DC-R02-0522-43000366-1 OE-19-DC (P1) REV. 02 (05-22)	SSESSOR	Real Property Div West Tasman Ca 130 W Tasman D San Jose, CA 951 Ph: (408) 299-530 RP@asr.sccgov.c	County Assessor ision mpus rive 34 00 org
Initial to, any disability or impairment that affects sight, speech, hearing, or the use of any limbs." (Revenue and Taxation Code section 74. I. TO BE COMPLETED BY A PHYSICIAN (please print) Patient's Name: Date of disability: Description of patient's disability:	ax benefit, a licensed physician or surgeon of appropriate spec he definition of a severely and permanently disabled person is irth or by reason of accident or disease, that results in	ialty must certify that th s, "… any person who a functional limitation a	www.sccassessor acement primary residence e disability of the claima has a physical disability as to employment or su	.org e. In order to qualify for th nt is severe and permanen / or impairment, whether fro bstantially limits one or mo
Patient's Name:	nited to, any disability or impairment that affects sight, speec			
Description of patient's disability: dentify: (1) the specific reasons why the disability necessitates a move to the replacement primary residence, and (2) the disability- related requirements, including any locational requirements, of a replacement primary residence: I am a licensed physician surgeon. My speciality is: 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 SURGEONS NAME (<i>pine or type</i>) II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (<i>please print</i>) NAME OF CLAIMANT RECORPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (<i>please print</i>) IN TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (<i>please print</i>) NAME OF CLAIMANT RECORPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (<i>please print</i>) NAME OF CLAIMANT RECORPTY ADDRESS CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (<i>check A or B</i>) CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (<i>check A or B</i>) CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (<i>check A or B</i>) CERTIFICATION OF DISABILITY are soft the State of California that the primary purpose of the move replacement primary residence is to satisfy the identified disability-related requirements described in Part 1. OR 1 Certify (or declare) under penalty of perjury under the identified disability-related requirements described in Part 1. OR 1 Certify (or declare) under penalty of perjury under the identified disability-related requirements described in Part 1. OR 1 Certify (or declare) under penalty of perjury under the identified disability-related requirements described in Part 1. OR 1 Certify (or declare) under penalty of perjury under the identified disability-related requirements described in Part 1. OR 1 Certify (or declare) under penalty of perjury under the state of California that the primary purpose of the move replacement primary residence i	I. TO BE COMPLETED BY A PHYSICIAN (please print)			
Identify: (1) the specific reasons why the disability necessitates a move to the replacement primary residence, and (2) the disability-related requirements, including any locational requirements, of a replacement primary residence: I am a licensed physician surgeon. My specialty is: 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 DATE PHYSICIAN OR SURGEONS NAME (primer type) DATE II. 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 PARCELID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) C 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-requirements identified in Part I (Part I must be completed by a physician or surgeor): C 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 replacement primary residence is to satisfy the identified disability-related requirements described in Part I. OR I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move replacement primary residence is to afteviate the financial	Patient's Name:		Date of disability:	
related requirements, including any locational requirements, of a replacement primary residence: I am a licensed physician I am a licensed physician 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 DATE PHYSICIAN OR SURGEON > DATE PHYSICIAN OR SURGEON > DATE I. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF SPOUSE OR LEGAL GUARDIAN NAME OF CLAIMANT NAME OF SPOUSE OR LEGAL GUARDIAN PROPERTY ADDRESS ASSESSOR'S PARCELID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) Assessor's parcellin number CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) Assessor's parcellin number CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) Assessor's parcellin number CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) Assessor's parcellin number A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence is to satisfy the identified disability-related requirements described in Part I. (Part I must be completed by a physician or surgeon): OR I certify (or declare) under penalty of perjury under the laws of the State of California that the prim	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'S 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 CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCELID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCELID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCELID NUMBER AND 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-re 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 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 replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain: NOR NOR NOR NOR NOR NOR NOR NO				e, 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. SIGNATURE OF PHYSICIAN OR SURGEON PHYSICIAN OR SURGEON'S NAME (print or type) II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (please print) NAME OF CLAIMANT NAME OF 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) 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-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 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 replacement primary residence is to alleviate the financial burdens caused by the disability. Placement primary residence is to alleviate the financial burdens caused by the disability. Placement primary purpose of the move replacement primary residence is to alleviate the financial burdens caused by the disabil	I am a licensedphysiciansurgeon. My specialty	is:		
SIGNATURE OF PHYSICIAN OR SURGEON PHYSICIAN OR SURGEON'S NAME (<i>print or type</i>) II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN (<i>please print</i>) NAME OF SPOUSE OR LEGAL GUARDIAN PROPERTY ADDRESS ASSESSOR'S PARCELID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (<i>check A or B</i>) ASSESSOR'S PARCELID NUMBER CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (<i>check A or B</i>) AND 2. 1 certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move replacement primary residence is to satisfy the identified disability-related requirements described in Part I. OR I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move replacement primary residence is to atleviate the financial burdens caused by the disability. Please explain: DATE SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME DATE DATE	CERTIF	CATION OF DISABILIT	Y	
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 SPOUSE OR LEGAL GUARDIAN NAME OF CLAIMANT NAME OF SPOUSE OR LEGAL GUARDIAN ASSESSOR'S PARCEL/ID NUMBER 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-re 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 replacement primary residence is to satisfy the identified disability-related requirements described in Part I. OR 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 primary residence is to alleviate the financial burdens caused by the disability. Please explain:	I certify that in my medical opinion, the above-named pa	atient does qualify as a di	sabled person according	to the definition above.
II. TO BE COMPLETED BY 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 CERTIFICATION OF DISABILITY-RELATED REQUIREMENTS (check A or B) ASSESSOR'S PARCEL/ID NUMBER AND ASSESSOR'S PARCEL/ID NUMBER AND ASSESSOR'S PARCEL/ID NUMBER ASSESSOR'S PARCEL/ID NUMER ASSESSOR'S PARCEL/ID NUMER ASSESSOR'S PARCEL/ID NUMER ASSESSOR'S PARCEL/ID NUMER ASSESSOR'S PARCEL/ID NUME PRINTED NAME ASSESSOR'S PARCEL/ID NUMER ASSESSOR'S PARCEL/ID NUMER ASSES	SIGNATURE OF PHYSICIAN OR SURGEON			DATE
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) Image: Certify (check a or b) A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-reception or surgeon): A: 1. The claimant, spouse, or legal guardian 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 replacement primary residence is to satisfy the identified disability-related requirements described in Part I. OR I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move replacement primary residence is to satisfy the identified disability-related requirements described in Part I. OR I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain:	PHYSICIAN OR SURGEON'S NAME (print or type)			DAYTIME PHONE NUMBER
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) Image: Certify (check a or b) A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-representation or surgeon): A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-replacements identified in Part I (Part I must be completed by a physician or surgeon): A: 1. certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move replacement primary residence is to satisfy the identified disability-related requirements described in Part I. OR 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 primary residence is to alleviate the financial burdens caused by the disability. Please explain: OR SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME DAYTIME PHONE NUMBER DATE () DATE				()
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-rerequirements 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 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 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 replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain: DAYTIME PHONE NUMBER ()				
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-rerequirements 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 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 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 replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain: DAYTIME PHONE NUMBER ()			4005000	
A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-rerequirements 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 replacement primary residence is to satisfy the identified disability-related requirements described in Part I. OR I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move 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 replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain: DAYTIME PHONE NUMBER ()	PROPERTY ADDRESS		ASSESSC	R'S PARCEL/ID NUMBER
	CERTIFICATION OF DISABIL	ITY-RELATED REQUIR	EMENTS (check A 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 primary residence is to satisfy the identified disability-related requirements described in Part I. I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move replacement primary residence is to alleviate the financial burdens caused by the disability. Please explain: 				e meets the disability-relat
Please explain:	replacement primary residence is to satisfy the id	r the laws of the State o lentified disability-relate OR	ed requirements describ	ed in Part I.
SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN	B: I certify (or declare) under penalty of perjury under t replacement primary residence is to alleviate the final	the laws of the State of ancial burdens caused b	California that the prima by the disability.	ry purpose of the move to
DAYTIME PHONE NUMBER () DATE	Please explain:			
()	SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN	PRINTED	NAME	
Length and the second s	DAYTIME PHONE NUMBER			DATE