

## **Deva Marie Proto** Sonoma County Clerk-Recorder-Assessor

585 Fiscal Dr., Rm 104 Santa Rosa, CA 95403 Telephone: (707) 565-1888 FAX: (707) 565-3317

## **CERTIFICATE OF DISABILITY**

The claimant listed below has applied to transfer their 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)

Patient's Name:  Description of patient's disability:  Identify: (1) the specific reasons why the disability necessitates a move including any locational requirements, of a replacement dwelling:		disability:  and (2) the disability-related requirements,
Identify: (1) the specific reasons why the disability necessitates a move	e to the replacement dwelling ar	nd (2) the disability-related requirements,
	e to the replacement dwelling ar	nd (2) the disability-related requirements,
I am a licensed physician surgeon. My specialty is: CERTIF	FICATION	
I certify that in my medical opinion the above named patient do	pes qualify as a disabled person a	according to the definition above.
PHYSICIAN'S SIGNATURE		DATE
PHYSICIAN'S NAME (print or type)		DAYTIME PHONE NUMBER
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR	LEGAL GUARDIAN (please prir	nt)
CLAIMANT'S NAME	SPOUSE'S NAME	
PROPERTY ADDRESS		ASSESSOR'S PARCEL NUMBER
CERTIFICATE OF DIS	SABILITY (check A or B)	
A: 1. The claimant or spouse must describe in their own words hidentified in Part I (Part I must be completed by a physicial)		eets the disability-related requirements
ANI  2. I certify (or declare) under penalty of perjury under the law replacement dwelling is to satisfy the identified disability-re	ws of the State of California that elated requirements described in	t the primary purpose of the move to the Part I.
B: I certify (or declare) under penalty of perjury under the laws replacement dwelling is to alleviate the financial burdens cause.	s of the State of California that	the 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

