EF-19-DC-R02-0522-03000068-1 BOE-19-DC (P1) REV. 02 (05-22)



## James B Rooney Assessor of Amador County

810 Court Street Jackson, CA 95642 PH: (209) 223-6351 FAX: (209) 223-6721

## **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)

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I. TO B	E COMPLETED BY A PHYSICIAN (please print)			
Patient's	Name:		Date of disab	ility:
Descript	ion of patient's disability:			
	(1) the specific reasons why the disability neces equirements, including any locational requirements			idence, and (2) the disability-
I am a lic		cialty is:	SABILITY	
1	certify that in my medical opinion, the above-name	ed p <mark>ati</mark> ent d <mark>oe</mark> s quall	ify as a disab <mark>led person</mark> acco	rding to the d <mark>efi</mark> nition above.
SIGNATURE OF PHYSICIAN OR SURGEON				DATE
PHYSICIAN	N OR SURGEON'S NAME (print or type)			DAYTIME PHONE NUMBER
II. TO B	E COMPLETED BY <mark>CL</mark> AIMANT, <mark>CLAIM</mark> ANT'S SI	POUSE, OR L <mark>EG</mark> AL	GUARDIAN (please print)	
NAME OF (	CLAIMANT	NAME	OF SPOUSE OR LEGAL GUARDIAN	
PROPERTY	/ADDRESS		AS	SESSOR'S PARCEL/ID NUMBER
	CERTIFICATION OF DISA	ABILITY-RELATED	REQ <mark>UIREMENTS (che</mark> ck A d	or B)
A:	The claimant, spouse, or legal guardian m requirements identified in Part I (Part I must be specified).			idence meets the disability-related
	I certify (or declare) under penalty of perjury			
	replacement primary residence is <b>to satisfy ti</b>	ne identified disabi OR	ity-related requirements de	escribed in Part I.
☐ B:	I certify (or declare) under penalty of perjury un replacement primary residence is <b>to alleviate the</b>		State of California that the caused by the disability.	primary purpose of the move to the
	Please explain:			
SIGNATURE	E OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN		PRINTED NAME	
DAYTIME P	HONE NUMBER		1	DATE
EMAIL ADD	RESS			I

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION

