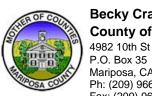
EF-62-A-R04-0810-22000226-1 BOE-62-A REV. 04 (08-10)

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)



Becky Crafts County of Mariposa Assessor/Recorder

P.O. Box 35 Mariposa, CA 95338 Ph: (209) 966-2332 Fax: (209) 966-5719

| I. TO BE COMPLETED BY A PHYSICIAN (please print) | | |
|---|--|--|
| Patient's Name: | Date of disability: | |
| Description of patient's disability: | 10 | Δ |
| Identify: (1) the specific reasons why the disability necessitates a move to the including any locational requirements, of a replacement dwelling: | replacement dwelling and (2 |) the <mark>dis</mark> ability-related requirements, |
| I am a licensed physician surgeon. My specialty is: CERTIFICATION I certify that in my medical opinion the above named patient does quality. | | rding to the definition above |
| PHYSICIAN'S SIGNATURE | .,, 40 4 4.040.04 po. 00.1 4000. | DATE |
| PHYSICIAN'S NAME (print or type) | | DAYTIME PHONE NUMBER |
| II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR LEGAL | | |
| CLAIMANT'S NAME \$POUS | SE'S NAME | |
| PROPERTY ADDRESS | AS | SESSOR'S PARCEL NUMBER |
| CERTIFICATE OF DISABILITY (check A or B) | | |
| A: 1. The claimant or spouse must describe in his or her own words how identified in Part I (Part I must be completed by a physician): | the replacement dwelling mee | ets the disability-related requirements |
| AND 2. I certify (or declare) under penalty of perjury under the laws of the replacement dwelling is to satisfy the identified disability-related reports. OR | | |
| B: I certify (or declare) under penalty of perjury under the laws of the replacement dwelling is to alleviate the financial burdens caused by t | State of California that the phe disability. | orimary purpose of the move to the |
| SIGNATURE OF CLAIMANT | DAYTIME PHONE NUMBER | DATE |
| | () DAYTIME PHONE NUMBER | DATE |
| SIGNATURE OF SPOUSE | () | DATE |

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION



F-MAIL ADDRESS