EF-19-DC-R02-0522-23000101-1 BOE-19-DC (P1) REV. 02 (05-22)



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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) | |
|---|---|
| Patient's Name: | Date of disability: |
| Description of patient's disability: Identify: (1) the specific reasons why the disability necessitates a mo | ve to the replacement primary residence and (2) the disability- |
| related requirements, including any locational requirements, of a replace | |
| I am a licensed physician surgeon. My specialty is: CERTIFICATION | OF DISABILITY |
| I certify that in m <mark>y medical opinion</mark> , the abo <mark>ve</mark> -n <mark>am</mark> ed p <mark>ati</mark> ent d <mark>oe</mark> | es q <mark>ua</mark> lify as a disab <mark>led person</mark> ac <mark>cording to th</mark> e d <mark>efi</mark> nition above. |
| SIGNATURE OF PHYSICIAN OR SURGEON | DATE |
| PHYSICIAN OR SURGEON'S NAME (print or type) | DAYTIME PHONE NUMBER |
| II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR I | LEGAL GUARDIAN (please pri <mark>nt)</mark> |
| NAME OF CLAIMANT | NAME OF SPOUSE OR LEGAL GUARDIAN |
| PROPERTY ADDRESS | ASSESSOR'S PARCEL/ID NUMBER |
| CERTIFICATION OF DISABILITY-REL | ATED REQUIREMENTS (check A or B) |
| A: 1. The claimant, spouse, or legal guardian must describe requirements identified in Part I (Part I must be completed | how the replacement primary residence meets the disability-related by a physician or surgeon): |
| AND 2. I certify (or declare) under penalty of perjury under the law replacement primary residence is to satisfy the identified | rs of the State of California that the primary purpose of the move to the |
| OR B: I certify (or declare) under penalty of perjury under the laws replacement primary residence is to alleviate the financial bu | of the State of California that the primary purpose of the move to the Indens caused by the disability. |
| Please explain: | |
| SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN | PRINTED NAME |
| DAYTIME PHONE NUMBER () | DATE |
| EMAIL ADDRESS | I |

