EF-19-DC-R02-0522-34000071-1 BOE-19-DC (P1) REV. 02 (05-22)



CHRISTINA WYNN SACRAMENTO COUNTY ASSESSOR

PROPERTY TRANSFER SECTION 3636 American River Drive, Suite 200 Sacramento, CA 95864-5952 Phone (916) 875-0750 FAX (916) 875-0755 https://assessor.saccounty.gov

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)

- and the discountry of impairment that anothe sight, special, hearing, or the	to doc or any miles. (Neverlae and	- Taxation Code Scotion 74.0)
I. TO BE COMPLETED BY A PHYSICIAN (please print)		
Patient's Name:	Date of disability:	
Description of patient's disability:		Λ
Identify: (1) the specific reasons why the disability necessitates a move to the related requirements, including any locational requirements, of a replacement process.		ce, and (2) the disability-
I am a licensed physician surgeon. My specialty is: CERTIFICATION OF DIS	SABILITY	
I certify that in my medical opin <mark>ion</mark> , the abo <mark>ve-nam</mark> ed p <mark>ati</mark> ent d <mark>o</mark> es q <mark>ua</mark> lif	iy as a disab <mark>led person</mark> a <mark>ccording</mark>	<mark>rto th</mark> e d <mark>efi</mark> nition above.
SIGNATURE OF PHYSICIAN OR SURGEON		DATE
PHYSICIAN OR SURGEON'S NAME (print or type)	ALLA POLAN (reference print)	DAYTIME PHONE NUMBER
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL NAME OF CLAIMANT	F SPOUSE OR LEGAL GUARDIAN	
PROPERTY ADDRESS	ASSESSO	OR'S PARCEL/ID NUMBER
CERTIFICATION OF DISABILITY-RELATED F	REQUIREMENTS (check A or B)	
A: 1. The claimant, spouse, or legal guardian must describe how the requirements identified in Part I (Part I must be completed by a physical section of the complete of the c	e replacement primary residence	ce meets the disability-related
AND		
 I certify (or declare) under penalty of perjury under the laws of the replacement primary residence is to satisfy the identified disability 		
B: I certify (or declare) under penalty of perjury under the laws of the replacement primary residence is to alleviate the financial burdens	State of California that the prima caused by the disability.	ary purpose of the move to the
Please explain:		
SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN	PRINTED NAME	
DAYTIME PHONE NUMBER ()	1	DATE
EMAIL ADDRESS		1

