EF-62-A-R05-0520-36000103-1 BOE-62-A REV. 05 (05-20)



## Josie Gonzales Assessor-Recorder-County Clerk

County of San Bernardino Assessor's Office 222 W. Hospitality Lane - 4th Floor San Bernardino, CA 92415-0311 www.sbcounty.gov/arc Phone: (909) 387-8307 Toll Free: (877) 885-7654

## **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)

Code Section 74.3)		
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 including any locational requirements, of a replacement dwelling:	the replacement dwelling and (2) the dis-	ability-r <mark>ela</mark> ted requirements,
CAAA	DIE	
I am a licensed physician surgeon. My specialty is:		
CERTIFIC		
I certify that in my medical opinion the above named patient does	· · · · · · · · · · · · · · · · · · ·	
PHYSICIAN'S SIGNATURE	DA	TE
PHYSICIAN'S NAME (print or type)	DA	YTIME PHONE NUMBER
II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE OR LE	GAL GUARDIAN (please print)	<u> </u>
CLAIMANT'S NAME	SPOUSE'S NAME	
PROPERTY ADDRESS  CERTIFICATE OF DISA		PARCEL NUMBER
A: 1. The claimant or spouse must describe in their own words how identified in Part I (Part I must be completed by a physician)		ility-related requirements
AND		
<ol> <li>I certify (or declare) under penalty of perjury under the laws replacement dwelling is to satisfy the identified disability-relations</li> <li>OR</li> </ol>		purpose of the move to the
B: I certify (or declare) under penalty of perjury under the laws or replacement dwelling is to alleviate the financial burdens caused		ourpose of the move to the
SIGNATURE OF CLAIMANT	DAYTIME PHONE NUMBER DA	TE
DIGNATURE OF OPOLICE	( )	-
SIGNATURE OF SPOUSE	DAYTIME PHONE NUMBER DAY	IE
E-MAIL ADDRESS	l /	