EF-19-DC-R02-0522-57000059-1 BOE-19-DC (P1) REV. 02 (05-22)



YOLO COUNTY COUNTY ASSESSOR

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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 move related requirements, including any locational requirements, of a replacement	
I am a licensed physician surgeon. My specialty is: CERTIFICATION OI	DISABILITY
I certify that in my medical opinion, the above-named patient does o	u <mark>a</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 LEG	GAL GUARDIAN (please pri <mark>nt)</mark>
NAME OF CLAIMANT	AME OF SPOUSE OR LEGAL GUARDIÁN
PROPERTY ADDRESS	ASSESSOR'S PARCEL/ID NUMBER
CERTIFICATION OF DISABILITY-RELAT	ED REQUIREMENTS (check A or B)
A: 1. The claimant, spouse, or legal guardian must describe ho requirements identified in Part I (Part I must be completed by	w the replacement primary residence meets the disability-related a physician or surgeon):
	of the State of California that the primary purpose of the move to the
replacement primary residence is to satisfy the identified dis OR	ability-related requirements described in Part I.
	the State of California that the primary purpose of the move to the ens caused by the disability.
Please explain:	
SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN	PRINTED NAME
DAYTIME PHONE NUMBER ()	DATE
EMAIL ADDRESS	l l

