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, or claimant's spouse, is severe. The definition of a severely disabled person is any person having a great degree of impairment or who is greatly limited by a physical, mental, cognitive, or developmental condition.

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 to the replacement primary residence and (2) the disability-related requirements, including any locational requirements, of a replacement primary residence:

I am a licensed ☐ physician ☐ surgeon. My specialty is: _____

CERTIFICATION OF DISABILITY

I certify that in my medical opinion, the above-named patient does qualify as a disabled person according to the definition 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 LEGAL GUARDIAN *(please print)*

NAME OF CLAIMANT	NAME OF SPOUSE OR LEGAL GUARDIAN
PROPERTY ADDRESS	ASSESSOR'S PARCEL/ID NUMBER

CERTIFICATE OF DISABILITY-RELATED REQUIREMENTS *(check A or B)*

☐ A: 1. The claimant, spouse, or legal guardian must describe how the replacement primary residence meets the disability-related requirements identified in Part I *(Part I **must** be completed by a physician or surgeon)*:

AND

2. *I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to the replacement primary residence is **to satisfy the identified disability-related requirements** described in Part I.*

OR

☐ B: *I certify (or declare) under penalty of perjury under the laws of the State of California that the primary purpose of the move to the replacement primary residence is **to alleviate the financial burdens** caused by the disability.*

Please explain: _____

SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN ▶	PRINTED NAME
DAYTIME PHONE NUMBER ( )	DATE
EMAIL ADDRESS	

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION