

## James B Rooney Assessor of Amador County

810 Court Street Jackson, CA 95642 PH: (209) 223-6351 FAX: (209) 223-6721

## **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)

Patient's Name:  Description of patient's disability:  Identify: (1) the specific reasons why the disability necessitates a move to the replaceme related requirements, including any locational requirements, of a replacement primary resider  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 disable signature of Physician or surgeon  PHYSICIAN OR SURGEON'S NAME (print or type)  II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN NAME OF CLAIMANT  NAME OF SPOUSE OR LEGAL GUARDIAN PROPERTY ADDRESS  CERTIFICATION OF DISABILITY-RELATED REQUIREME!  A: 1. The claimant, spouse, or legal guardian must describe how the replaceme	
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II. TO BE COMPLETED BY CLAIMANT, CLAIMANT'S SPOUSE, OR LEGAL GUARDIAN NAME OF CLAIMANT  PROPERTY ADDRESS  CERTIFICATION OF DISABILITY-RELATED REQUIREMENT	DATE
PROPERTY ADDRESS  CERTIFICATION OF DISABILITY-RELATED REQUIREMENT	DAYTIME PHONE NUMBER
CERTIFICATION OF DISABILITY-RELATED REQUIREMENT	
	ASSESSOR'S PARCEL/ID NUMBER
A: 1. The claimant, spouse, or legal guardian must describe how the replaceme	NTS (c <mark>he</mark> ck A or B)
requirements identified in Part I (Part I must be completed by a physician or sur	
AND	
<ol> <li>I certify (or declare) under penalty of perjury under the laws of the State of Calareplacement primary residence is to satisfy the identified disability-related re</li> </ol>	
B: I certify (or declare) under penalty of perjury under the laws of the State of California replacement primary residence is <b>to alleviate the financial burdens</b> caused by the	ornia that the primary purpose of the move to the disability.
Please explain:	
SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN PRINTED NAME	
DAYTIME PHONE NUMBER ( )	DATE

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION

