EF-19-DC-R02-0522-17000141-1 BOE-19-DC (P1) REV. 02 (05-22)



Douglas W. Wacker County Assessor-Recorder

Lake County Courthouse 255 North Forbes Street Lakeport, CA 95453

Assessor's Office Phone: 707-263-2302 Recorder's Office Phone: 707-263-2293

Fax: 707-263-3703

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>y</i> (
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 related requirements, including any locational requirements, of a re	a move to the replacement primary residence, and (2) the disability-placement primary residence:
I am a licensed physician surgeon. My specialty is:	TION OF DISABILITY
I certify that in my medical opin <mark>ion</mark> , the abo <mark>ve</mark> -n <mark>am</mark> ed p <mark>ati</mark> en	nt d <mark>oe</mark> s q <mark>ua</mark> lify as a disab <mark>led person</mark> a <mark>ccording 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 LEGAL GUARDIAN (please print)
NAME OF CLAIMANT	NAME OF SPOUSE OR LEGAL GUARDIAN
PROPERTY ADDRESS	ASSESSOR'S PARCEL/ID NUMBER
CERTIFICATION OF DISABILITY	-RELATED REQUIREMENTS (check A or B)
A: 1. The claimant, spouse, or legal guardian must descrequirements identified in Part I (Part I must be completed)	cribe how the replacement primary residence meets the disability-related eted by a physician or surgeon):
	AND
	e laws of the State of California that the primary purpose of the move to the ified disability-related requirements described in Part I.
B: I certify (or declare) under penalty of perjury under the replacement primary residence is to alleviate the financ .	OR laws of the State of California that the primary purpose of the move to the ial burdens caused by the disability.
Please explain:	
SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN	PRINTED NAME
DAYTIME PHONE NUMBER	DATE
()	
EMAIL ADDRESS	·

