

Rolf D. Kleinhans Nevada County Assessor 950 Maidu Avenue P.O. Box 599002 Nevada City, CA 95959-7902 Telephone (530) 265-1232 Fax (530) 265-9858 assessor@nevadacountyca.gov

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.	то	BE	COMPL	ETED.	BY A	PHYSICIAN	(please	print)
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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 r	a move to the replacement primary residence, and (2) the disability- eplacement primary residence:
I am a licensedphy <mark>sician</mark> surgeon. My specialty is	
	ATION OF DISABILITY
I Certify that in my medical opinion, the above-named patters	ent does q <mark>ua</mark> lify as a disab <mark>le</mark> d person according to the d <mark>efi</mark> nition above.
	DAL
PHYSICIAN OR SURGEON'S NAME (print or type)	DAYTIME PHONE NUMBER
II. TO BE COMPLETED BY <mark>CL</mark> AIMANT, <mark>C</mark> LAI <mark>M</mark> ANT'S SP <mark>OU</mark> SE	
NAME OF CLAIMANT	NAME OF SPOUSE OR LEGAL GUARDIAN
PROPERTY ADDRESS	ASSESSOR'S PARCEL/ID NUMBER
	Y-RELATED REQUIREMENTS (check A or B)
A: 1. The claimant, spouse, or legal guardian must deer requirements identified in Part I (Part I must be comp requirements)	scribe how the replacement primary residence meets the disability-related by a physician or surgeon):
	AND
	he laws of the State of California that the primary purpose of the move to the ntified 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 finance	e laws of the State of California that the primary purpose of the move to the cial burdens caused by the disability.
Please explain:	
SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN	PRINTED NAME
DAYTIME PHONE NUMBER	DATE
() EMAIL ADDRESS	
EWAIL ADDRESS	
	SUBJECT TO PUBLIC INSPECTION