EF-19-DC-R02-0522-57000122-1 BOE-19-DC (P1) REV. 02 (05-22)



YOLO COUNTY COUNTY ASSESSOR

625 Court St, Rm. 104 Woodland, CA 95695 Woodland/Davis (530) 666-8135 West Sacramento (916) 375-6496 Fax (530) 666-8213 assessor@yolocounty.org

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 national dischility.			
Description of patient's disability:			
Identify: (1) the specific reasons why the disability related requirements, including any locational require			ice, and (2) the disability-
I am a licensed physician surgeon. M	ly spe <mark>cialt</mark> y is:CERTIFICATION OF DISABILI	TY	
I certify that in my medical opinion, the above	-n <mark>am</mark> ed p <mark>ati</mark> ent d <mark>oe</mark> s q <mark>ua</mark> lify as a	disab <mark>led person</mark> accordin	g to the d <mark>efi</mark> nition above.
SIGNATURE OF PHYSICIAN OR SURGEON			DATE
PHYSICIAN OR SURGEON'S NAME (print or type) II. TO BE COMPLETED BY CLAIMANT, CLAIMAN	T'S SPOUSE OF LECAL CHAP	IDIAN (plage print)	DAYTIME PHONE NUMBER
NAME OF CLAIMANT		SE OR LEGAL GUARDIAN	
PROPERTY ADDRESS		ASSES	SOR'S PARCEL/ID NUMBER
CERTIFICATION	F DISABILITY-RELATED REQUI	REMENTS (check A or B)
A: 1. The claimant, spouse, or legal guard requirements identified in Part I (Part I n	ian mu <mark>st describe how the repl</mark>	acement primary reside	
I certify (or declare) under penalty of per replacement primary residence is to sate.	tisfy the identified disability-rela		
B: I certify (or declare) under penalty of perior replacement primary residence is to allevi	OR ury under the laws of the State o ate the financial burdens caused	of California that the prim d by the disability.	eary purpose of the move to the
Please explain:			
SIGNATURE OF CLAIMANT, SPOUSE, OR LEGAL GUARDIAN	PRINTI	ED NAME	
DAYTIME PHONE NUMBER			DATE
EMAIL ADDRESS			

THIS DOCUMENT IS NOT SUBJECT TO PUBLIC INSPECTION

