EF-19-DC-R02-0522-57000081-1 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)

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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 related requirements, including any locational requirements, of a rep	move to the replacement primary residence, and (2) the disability-lacement primary residence:
I am a licensed physician surgeon. My specialty is:	ION OF DISABILITY
I certify that in my medical opinion, the above-named patient	does qualify as a disab <mark>led person according to th</mark> e 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, C	
NAME OF CLAIMANT	NAME OF SPOUSE OR LEGAL GUARDIÁN
PROPERTY ADDRESS	ASSESSOR'S PARCEL/ID NUMBER
CERTIFICATION OF DISABILITY-F	RELATED REQUIREMENTS (check A or B)
A: 1. The claimant, spouse, or legal guardian must descr requirements identified in Part I (Part I must be completed)	ibe how the replacement primary residence meets the disability-related ted by a physician or surgeon):
	ND
replacement primary residence is to satisfy the identif	laws of the State of California that the primary purpose of the move to the ied disability-related requirements described in Part I.
	DR laws of the State of California that the primary purpose of the move to the I 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

