

**PHYSICIAN'S CERTIFICATION
OF
TOTAL AND PERMANENT DISABILITY**

THIS FORM MUST BE FILLED OUT COMPLETELY

TAXPAYER NAME _____ DOCTOR NAME _____
ADDRESS _____ ADDRESS _____
SOCIAL SECURITY # _____ PHONE _____

I, _____, a licensed physician of the State of Florida, hereby certify Mr. ___Mrs. ___Miss ___ _____ is Totally and Permanently disabled as of January 1st _____ due to the following mental or physical condition(s):

The above named may be classified as: (must check one below) and explain condition in space provided above.

- QUADRIPLEGIC
- PARAPLEGIC
- HEMIPLEGIC
- LEGALLY BLIND
- TOTALLY and PERMANENTLY disabled person confined to a wheelchair for mobility.
- TOTALLY and PERMANENTLY disabled person confined to BED and is immobile.
- NONE of the above.

The foregoing statements are true, correct, and complete to the best of my knowledge and professional belief.

Signature: _____
Date: _____
Florida Board Medical Examiner's
License No. _____
Issued On: _____

NOTICE TO TAXPAYER: Each Florida resident applying for a Total and Permanent Disability Exemption must present to the County Appraiser on or before March 1. TWO copies of this form (or a letter from the United States Veterans Administration) Each form is to be completed by a Florida licensed physician. The Physicians must be professionally unrelated.

NOTICE TO TAXPAYER AND PHYSICIAN: Section 196.131(2), Florida Statutes, states that "Any person who knowingly gives false information for the purpose of claiming homestead exemption as provided for in this chapter is guilty of a misdemeanor of the first degree, punishable as provided in S.775.082 or by fine not exceeding \$2,500, or both."