Print Clear Form

CERTIFICATION OF DISABILITY FOR PROPERTY TAX EXEMPTION

(VETERANS PLEASE USE FORM 82514V)

Pursuant to Article IX, Section 2 of the Arizona Constitution, A.R.S. Title 42, Chapter 11, Article 3, § 42-11111 and Article 4, §§ 42-11151, 42-11152, 42-11153.

This form can be completed on-line and then printed, or it can be printed and completed manually. To assure that the exemption affidavit (DOR 82514) is processed for the current Tax Year, if hand-delivered, the copy of this form which has the applicant's and the Medical Authority's signatures **MUST** be filed along with the copy of the DOR 82514 Affidavit of Individual Tax Exemption form with the County Assessor of the county in which the applicant's property is located no later than the last business day in February. If this form and the DOR 82514 are mailed to the County Assessor, they must be postmarked on or before the last business day of February.

Applicant's Name: _____
(Type or Print) (Last, First and Initial)

Street Address: _____

City, State, Zip Code: _____

Email Address _____ Date of Birth:_____ Marital Status: ☐ Single ☐ Married

Applicant's Signature: _____ Date Signed: _____

Exemption for Totally and Permanently Disabled Person
Pursuant to A.R.S. § 42-11111 (K)(1) "Competent Medical Authority" means any of the following:

(a) An individual licensed under Title 32, Chapter 8, 13, 14, 17, 19.1, 25 or 29 or comparable law of another state.
(b) A registered nurse practitioner as defined in Section 32-1601.
(c) The United States Department of Veterans Affairs, as evidenced by a disability award letter.

A.R.S. § 42-11111 (K)(3) "Person with a total and permanent disability" means:
A person who is unable to engage in any substantial gainful activity, for pay or profit, by reason of any physical or mental impairment that is expected to last for a continuous period of at least twelve months or result in death within twelve months as certified by a competent medical authority.

MEDICAL CERTIFICATION FOR TOTALLY AND PERMANENTLY DISABLED PERSONS

THE FOLLOWING IS TO BE COMPLETED BY THE EXAMINING MEDICAL AUTHORITY:

I hereby certify the applicant's condition as stated below:

The above-named applicant is unable to engage in any substantial gainful activity and therefore is considered to be totally and permanently disabled as defined above. YES ☐ NO ☐

Type or Print

_____
Medical Authority's Name

_____
Business Address

_____
City, State, Zip Code

_____
Phone Number

_____ _____
Medical Authority's Signature Date

Medical Authority's Office Stamp: