



PHYSICIAN'S AFFIDAVIT OF PERMANENT AND TOTAL DISABILITY

NAME OF PERSON EXAMINED _____

Address _____

City _____ State _____ Zip Code _____

I am actively providing treatment directly related to the permanent and total disability of the person named above seeking this exemption. Yes _____ No _____

My professional opinion is that the person named above is permanently and totally disabled. Yes _____ No _____

The person named above seeking this exemption has been permanently and totally disabled since _____

AFFIDAVIT OF PHYSICIAN

I, _____, certify that I have personally examined the physical condition of the above named individual and determined him or her to be permanently and totally disabled. I understand that according to Title 40-9-21.2 "any person who knowingly and willfully gives false information for the purpose of claiming a homestead exemption, or for the purpose of assisting another person in claiming a homestead exemption, shall be ordered to pay twice the amount of any ad valorem tax which would have been due retroactive for a period of up to 10 years plus interest at a rate of 15 percent per annum from the date the tax would have been due."

SIGNATURE OF PHYSICIAN _____

PHYSICIAN NAME _____

CURRENT ALABAMA MEDICAL LICENSE NUMBER _____ ISSUE DATE _____ EXPIRATION DATE _____

BUSINESS ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____

DATE _____