FULTON COUNTY BOARD OF ASSESSORS
Homestead Division
Physician's Disability Certification

CLAIMANT'S NAME _____

ADDRESS _____

PARCEL ID# _____ PHONE# _____

This is to certify that in my opinion _____
is mentally or physically incapacitated to the extent that he/she is unable to be gainfully employed and that such incapacity is likely to be permanent.

I further certify that I am licensed to practice medicine under Chapter 34 of Title 43 of the O.C.G.A., relative to medical practitioners, as now or hereafter amended.

I understand that a representative from the Fulton County Assessors' Office may contact my office to verify this information.

_____
Doctor's Name (Please Print)

_____
Doctor's Signature

_____
Office Address

_____
Office Phone Number

Sworn to and subscribed before me
this _____day of _____20_____.

_____
Notary Public

My commission expires: _____ SEAL

Revised January 2019