

**PHYSICIAN'S STATEMENT  
FOR DISABILITY HOMESTEAD EXEMPTION  
FOR TAX YEAR \_\_\_\_\_**

A completed disabled person's Residential Homestead Exemption application must be filed with this statement:

Applicant's Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Property Account# \_\_\_\_\_

*Disability for the purpose of these exemptions means that:*

- (a) *a person is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; or*
- (b) *a person 55 or older and blind is unable, due to blindness, to engage in substantial gainful activity in which he has previously engaged with some regularity and over a substantial period of time.*

**Physician, please provide the following information:**

1. How long have you treated the applicant for the disabling condition? \_\_\_\_\_
2. When did the applicant last work? \_\_\_\_\_
3. When do you expect the applicant to be able to return to work? \_\_\_\_\_
4. Please state in layman's terms the condition for which the applicant is being or has been treated. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

The person identified at the top of this form has been examined by me and based on the above definition, he or she was disabled on \_\_\_\_\_

**(Date Disability began)**

**Physician's Signature** \_\_\_\_\_

Date Signed \_\_\_\_\_

Physician's Printed Name \_\_\_\_\_

Physician's License Number \_\_\_\_\_

Physician's Office Phone# \_\_\_\_\_

Physician's Office Address \_\_\_\_\_

\_\_\_\_\_

**Return to:** Collin Central Appraisal District  
250 W Eldorado Pkwy  
McKinney, Texas 75069

469-742-9200