BRITISH COLUMBIA

Ministry of
Provincial Revenue
Property Taxation Branch
www.rev.gov.bc.ca/rpt

PHYSICIAN CERTIFICATION
PROPERTY TAX DEFERMENT PROGRAM

If you have any questions or require additional information regarding application for the Property Tax Deferment Program, please call our office at: 250 387-0555 in Victoria, or toll-free through Enquiry BC: 1 800 663-7867 from within BC or 604 660-2421 from Vancouver, and request a transfer to 387-0555.

Freedom of Information and Protection of Privacy Act
The personal information requested on this form is collected under the authority of the *Land Tax Deferment Act* and will be used to process your application. Questions about the collection or use of this information can be directed to the Property Taxation Branch at 250 387-0555 or PO Box 9446 Stn Prov Govt, Victoria BC V8W 9V6.

HOMEOWNER INSTRUCTIONS:

If you wish to apply to defer your property taxes under the person with a disability provision:

1. Submit one of the following to our office:
   a) a copy of either a recent letter confirming your Persons with Disability designation or your Consent for Release of Information Form from the Ministry of Human Resources, OR
   b) IF YOU DO NOT HAVE EITHER OF THE ABOVE DOCUMENTS, take this form to your physician. Your physician will complete the form to confirm that you are a person with a disability as set out below, and will then mail it to us. It is the applicant's responsibility to ensure that this form is forwarded to the address below.
2. Apply for deferment of property taxes and your home owner grant at your municipal or government agent office.

PHYSICIAN MUST COMPLETE

- Your patient has requested you to complete the form to establish their eligibility for the property tax deferment program.
- Please type or print clearly.
- ***Your assistance is appreciated!***

When complete, please mail form to:

Tax Deferment Program
Ministry of Provincial Revenue
PO Box 9446 Stn Prov Govt
Victoria BC V8W 9V6

PATIENT NAME	PATIENT PHONE NUMBER
	( )

PATIENT MAILING ADDRESS

	POSTAL CODE

I certify that my patient:

		YES	NO
1.	is 18 years of age or older;	☐	☐
2.	has a severe mental or physical impairment that in my opinion		
	a) is likely to continue for at least 2 years, and	☐	☐
	b) directly and significantly restricts the person's ability to perform daily living activities either		
	(i) continuously, or		
	(ii) periodically for extended periods, and	☐	☐
	c) as a result of those restrictions, the person requires help to perform those activities in the form of		
	(i) an assistive device,		
	(ii) the significant help or supervision of another person, or		
	(iii) the services of an assistive animal.	☐	☐

Please continue on reverse

PRIMARY DIAGNOSIS

Please describe the severe mental or physical impairment (for example: functional abilities, cognitive abilities, interpersonal abilities or social abilities).

Describe in **DETAIL** what restrictions (if any) the applicant's severe impairment poses to daily living activities. Please specify any help that may be necessary including assistive devices, assistive persons, or assistive animals.

PHYSICIAN'S CERTIFICATION – I hereby certify that, to the best of my knowledge, the above information is true and correct.

PHYSICIAN'S NAME – *please print*

PHYSICIAN'S ADDRESS

CITY	PROVINCE	POSTAL CODE	PHONE NO.
			( )

PHYSICIAN'S SIGNATURE

X

DATE SIGNED
YYYY MM DD