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_____