



# 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 \_\_\_\_\_.  
Month/day/year

## 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 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 \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE \_\_\_\_\_ DATE \_\_\_\_\_

Mobile County Revenue Commissioner  
P. O. Drawer 1169  
Mobile, Al 36633  
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