City of Chesapeake

Commissioner of the Revenue
Post Office Box 15285
Chesapeake, Virginia 23328

MEDICAL AFFIDAVIT FOR REAL ESTATE TAX RELIEF

Authorization for Disclosure of Health Information: *To Be Completed by the Tax Relief Applicant*

I, _____, of _____, Chesapeake, Virginia, voluntarily
Name of Tax Relief Applicant — Street Address of Applicant
consent and authorize _____, MD to disclose my *individually identifiable health*
Name of Licensed Medical Physician
information to the *City of Chesapeake, Commissioner of the Revenue's Office* (Recipient) for my applying for the City's Real Estate Tax Relief Program.

_____	_____	_____
Name of Applicant (Please Type or Print)	Signature of Applicant	Date
_____	_____	_____
Name of Witness (Please Type or Print)	Signature of Witness	Date

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Medical Affidavit: *To Be Completed by Physician*

I, _____, M.D. do solemnly swear that I am licensed to practice medicine in
Name of Licensed Medical Physician
the State of Virginia, that I thoroughly examined _____ on _____, and I
Name of Patient — Date
find him/her to have a medically determinable physical/mental disability preventing substantial gainful activity and is expected to result in death or last for the duration of his/her life. The condition(s) found to be *permanent and totally disabling* as defined in **§58.1-3217 of the Code of Virginia**, is/are specifically described below:

_____
_____

Code of Virginia §58.1-3217: "***Permanently and totally disabled*** shall mean unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment or deformity which can be expected to result in death or can be expected to last for the duration of such person's life."

As defined in state code, is the medical condition(s) described above found to be totally disabling? ☐ Yes ☐ No

As defined in state code, is the medical condition(s) described above found to be permanent in nature? ☐ Yes ☐ No

If patient is permanently and totally disabled, does he/she require fulltime, 24-hour care due to the medical condition(s) described above and is unable to care for oneself? ☐ Yes ☐ No

Does the patient reside in a nursing home or similar facility? ☐ Yes ☐ No

_____	_____	_____
Name of Physician (Please Type or Print)	Signature of Physician	Date

Virginia Medical Lic# _____ Address: _____, VA_____
Street Address — City — Zip

_____	_____	_____
Name of Witness (Please Type or Print)	Signature of Witness	Date