BRITISH COLUMBIA | Ministry of Finance

INSTRUCTIONS FOR COMPLETING THE TREATMENT CERTIFICATION

under the Speculation and Vacancy Tax Act

GENERAL INFORMATION

Use this form if you are a property owner and you:

- claimed the **secondary residence close to medical treatment facility** exemption on your speculation and vacancy tax declaration (as outlined in section 45 of the Act), or
- claimed the **away from home for medical reasons** exemption on your speculation and vacancy tax declaration (as outlined in section 33 of the Act), or
- chose one of the above as an eligible use on the tax credit application.

An "owner" can also mean a life tenant, a holder of the last registered agreement for sale, or in some cases a registered leaseholder. If you are applying as a corporation, trust or partnership, an "owner" means corporate interest holder, beneficial owner or partnership interest holder.

STEP 1 – Complete this form in full as incomplete information will delay the processing of your certification. If you are completing this form on behalf of an owner, a copy of a Power of Attorney or an Authorization or Cancellation of a Representative (**FIN 146**) must be submitted with this form, if one has not already been submitted. Make sure:

- you, as the owner, complete and sign **Part 1**,
- the patient receiving medical treatment (you, your spouse or your child) completes and signs **Part 2**, and
- the patient receiving medical treatment brings this form to their **medical practitioner** to complete **Part 3**. A medical practitioner is a member of the BC College of Physicians and Surgeons, or similar in other jurisdictions. See our **website** for more details.

Note: For Part 1 and/or Part 2, an adult guardian must sign on behalf of a child under the age of 19.

STEP 2 – Submit your form using one of the following methods:

- **Securely Attach Online (recommended):** Scan this completed form and attach it to your online speculation and vacancy tax declaration. To add an attachment, go to **gov.bc.ca/spectax**, click on the Declare Now button, choose "I want to change or continue an existing declaration", log in and use the "Add" button within the declaration.
- **By Mail:** Ministry of Finance
  Property Taxation Branch
  PO Box 9472 Stn Prov Govt
  Victoria BC V8W 9W6

NEED MORE INFORMATION?

- See our website at **gov.bc.ca/spectax**
- Call us toll free at **1-833-554-2323**

BRITISH COLUMBIA | Ministry of Finance

Mailing Address:
PO Box 9472 Stn Prov Govt
Victoria BC V8W 9W6
gov.bc.ca/spectax

TREATMENT CERTIFICATION

under the Speculation and Vacancy Tax Act

See instructions on Page 1.

Freedom of Information and Protection of Privacy Act (FOIPPA) – The personal information on this form is collected for the purpose of administering the Speculation and Vacancy Tax Act under the authority of section 26(a) and 26(c) of the FOIPPA. Questions about the collection or use of this information can be directed to the Director, Annual Property Tax, Ministry of Finance, PO Box 9472 Stn Prov Govt, Victoria BC V8W 9W6 (telephone: toll free at 1-833-554-2323).

PART 1 – PROPERTY OWNER INFORMATION

FULL LEGAL NAME OF OWNER	DATE OF BIRTH YYYY / MM / DD

LEGAL NAME OF CORPORATION, TRUST OR PARTNERSHIP (if applicable)	BUSINESS NUMBER (if applicable)	TRUST NUMBER (if applicable)

PROPERTY ADDRESS (include unit or house number, street name and city)	POSTAL CODE

SPECULATION AND VACANCY DECLARATION LETTER ID	TELEPHONE NUMBER	EMAIL ADDRESS (optional)
L		

Check (✓) the medical exemption you claimed. A medical practitioner must complete the certification in Part 3.

☐ **(A) Secondary residence close to medical treatment facility (section 45)** – applies when a secondary residence is periodically occupied by an owner (or their spouse or child) so they can participate in a course of treatment required for their health at a facility that is close to this residence.

☐ **(B) Away from home for medical reasons (section 33)** – applies when an owner was previously living at this residence as their principal residence but is away from their residence for a continuous extended period to receive a course of treatment required for the health of an owner, owner's spouse or owner's minor child. It would be impractical to obtain the medical treatment at a location closer to the residence.

Property Owner Certification – I certify that all information provided in Part 1 of this form is true and correct to the best of my knowledge and belief. I understand all information is subject to audit and verification.

SIGNATURE	DATE SIGNED YYYY / MM / DD
X	

PART 2 – PATIENT RECEIVING MEDICAL TREATMENT

FULL NAME OF PATIENT (complete even if owner named above)	PATIENT'S RELATIONSHIP TO OWNER (if owner, enter owner)	MEDICAL TREATMENT FACILITY NAME

MEDICAL TREATMENT FACILITY ADDRESS (include street or PO box, city, province/state/territory and country)	POSTAL CODE

Patient Certification – I certify that all information provided in Part 2 of this form is true and correct to the best of my knowledge and belief. I understand all information is subject to audit and verification.

SIGNATURE	DATE SIGNED YYYY / MM / DD
X	

PART 3 – MEDICAL PRACTITIONER'S CERTIFICATION – TO BE COMPLETED BY A MEDICAL PRACTITIONER ONLY

Once completed, return the form to the individual with the medical condition.

FULL LEGAL NAME OF MEDICAL PRACTITIONER	CERTIFICATION / FELLOWSHIP	TELEPHONE NUMBER

MAILING ADDRESS (include street or PO box, city, province/state/territory and country)	POSTAL / ZIP CODE

I certify that in my professional opinion, the patient noted in Part 2 is participating in a course of treatment that is required for the health of the individual.

SIGNATURE OF MEDICAL PRACTITIONER	DATE SIGNED YYYY / MM / DD
X	

Print Form | Clear Form