BRITISH COLUMBIA | Ministry of Finance

Mailing Address:
PO Box 9472 Stn Prov Govt
Victoria BC V8W 9W6

PHYSICIAN CERTIFICATION

under the *Speculation and Vacancy Tax Act*

INSTRUCTIONS

- Use this form if you are a property owner and claimed a medical exemption on your speculation and vacancy tax declaration or completed the tax credit application.
- If you are applying as a corporation, trust or partnership, an "owner" means corporate interest holder, beneficial owner or partnership interest holder.
- Print and sign your completed form and bring it to your **medical practitioner** to complete **Page 2**.
- Mail your completed form to the address listed above or scan and email it with "Physician Certification" and your name in the subject line.

GENERAL INQUIRIES

Toll-free: 1 833 554-2323
Outside North America: 1 (604) 660-2421
Email: **spectaxinfo@gov.bc.ca**
Website: **gov.bc.ca/spectax**

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, CORPORATION, TRUST OR PARTNERSHIP		BUSINESS NUMBER (*if applicable*)	DATE OF BIRTH YYYY / MM / DD
MAILING ADDRESS (*include street or PO box, city, province/state/territory and country*)			POSTAL / ZIP CODE
SPECULATION AND VACANCY DECLARATION CONFIRMATION NUMBER (*if available*)	TELEPHONE NUMBER	EMAIL ADDRESS	

PART 2 – PROPERTY OWNER CERTIFICATION

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

Check (✓) the medical exemption you claimed. Your medical practitioner must complete the certification in **Part 4**. If your medical practitioner does not certify in Part 4, you must contact us. See our **website** for more information.

☐ **(A) Secondary residence close to medical treatment facility** – applies when a secondary residence is periodically occupied by an owner (or the owner's spouse or child) so they can receive required medical treatment at a facility that is close to the residence.

NAME OF PATIENT RECEIVING MEDICAL TREATMENT (*complete even if same name as owner*)	PATIENT'S RELATIONSHIP TO OWNER

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

NAME OF PATIENT RECEIVING MEDICAL TREATMENT (*complete even if same name as owner*)	PATIENT'S RELATIONSHIP TO OWNER

☐ **(C) Living apart from spouse for health reasons** – applies when spouses must live apart for certain medical reasons and a residence on a property was the principal residence of the owner's spouse but not of the owner.

Please explain the condition that prevents you from residing with your spouse in their principal residence:

I certify that all information provided on this form is true and correct to the best of my knowledge and belief. All information is subject to audit and verification.

SIGNATURE OF OWNER	DATE SIGNED YYYY / MM / DD
X	

CONTINUE ON PAGE 2

PART 3 – MEDICAL PRACTITIONER'S INFORMATION

- **To be completed by a medical practitioner only.**
- **Once completed, return the form to the patient.**

FULL LEGAL NAME OF MEDICAL PRACTITIONER	TYPE OF MEDICAL PRACTITIONER	TELEPHONE NUMBER

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

PART 4 – MEDICAL PRACTITIONER'S CERTIFICATION

I certify that in my professional opinion (*check* (✓) *one*):

☐ My patient ______________________________, is receiving treatment required for their
(*print patient name in full*)
health as indicated in Part 2, either **(A) Secondary residence close to medical treatment facility** or **(B) Away from home for medical reasons**.

OR

☐ My patient ______________________________, has a health condition as indicated and
(*print patient name in full*)
explained in Part 2 **(C) Living apart from spouse for health reasons**.

I certify that to the best of knowledge, the above information is true and correct.

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