MARYLAND STATE DEPARTMENT OF ASSESSMENTS & TAXATION
APPLICATION FOR EXEMPTION FOR DISABLED ACTIVE DUTY SERVICE MEMBER

To be filed with the Supervisor of Assessments at the appropriate office; a list of offices is attached.

This form seeks information for the purpose of a disabled active duty service member's exemption on the indicated property. Failure to provide this information will result in denial of your application. However, some of this information would be considered a "personal record" as defined in General Provisions Article, §4-501. Consequently, you have the statutory right to inspect your file and to file a written request to correct or amend any information you believe to be inaccurate or incomplete. Additionally, personal information provided to the State Department of Assessments and Taxation is not generally available for public review. However, this information is available to officers of the State, county or municipality in their official capacity and to taxing officials of any State or the federal government, as provided by statute.

Full Name of Property Owner(s): _____

County Account Number: _____ (Baltimore City) Ward ___ Section ___ Block _____ Lot _____

Address of Property: _____

Is this property the principal residence of the disabled active duty service member: ☐ YES ☐ NO

Current Duty Station *(Name & Location)*: _____

Most Recent Enlistment Date: _____ Active Duty Enlistment Term Expires: _____

☐ Check to apply for a refund of any property tax paid for which you may be eligible under Tax Property Article 7-208.

NOTE: Each year the applicant will be required to provide certification of their active duty status for the continuation of this exemption.

I declare under the penalties of perjury, pursuant to Section 1-201, Tax Property Article, of the Annotated Code of Maryland, that this application has been examined by me and to the best of my knowledge and belief is a true, correct and complete application.

_____ _____ _____
Signature of Disabled Active Duty Service Member Date Daytime Phone

_____ _____
Printed Name of Disabled Active Duty Service Member Email Address

_____
Current Mailing Address *(if different than address of property)*

MEDICAL CERTIFICATION *(To be completed in full by a licensed Maryland or Veteran Administration physician whose care the applicant is under.)*

Description of service connected physical disability:_____

_____

Disability is service connected: ☐ YES ☐ NO Nature of disability: ☐ Permanent ☐ Temporary

Disability caused or incurred by misconduct: ☐ YES ☐ NO Effective date of disability: _____

I, the undersigned, do hereby certify the applicant has been examined by me for the above stated service connected disability date, description and extent of this disability are true and accurate.

_____ _____ _____
Physician's Signature Date Office Phone

_____ _____
Physician's Printed Name Physician's Office Address

ACTIVE DUTY CERTIFICATION *(To be signed by applicant's Commanding Officer)*

I, the undersigned, do hereby certify the service member above is active duty under my command and their active duty enlistment date and expiration term are true and accurate.

_____ _____ _____
Commanding Officer's Signature Date Office Phone

_____ _____
Commanding Officer's Printed Name Rank

ASSESSMENT OFFICE USE ONLY

Comments: _____ Approved ☐ Effective Date: _____ Disapproved ☐

Supervisor's Signature: _____ Date: _____