

**West Contra Costa Healthcare District
2000 Vale Road
San Pablo, CA 94806**

Request for Exemption from Parcel Tax

Name of Parcel Owner: _____

Address: _____

City, State and Zip Code: _____

Telephone: _____ E-mail (optional): _____

Address of Subject Parcel:

Number of Subject Parcel:

(Please attach: (a) a copy of the tax bill showing the tax for which exemption is sought and, (b) if appropriate, cancelled check(s) showing any parcel tax payment.)

Basis for requesting exemption from parcel tax: _____

(Attach photographs or other graphic representation that you believe could assist us in determining whether a basis for exemption exists.)

Please include any other information you believe will assist us in evaluating your request:

Signature:

D a t e :