Print and Reset Form Reset Form

STATE OF CALIFORNIA
FRANCHISE TAX BOARD
PO BOX 942840
SACRAMENTO CA 94240-0040

Mandatory e-Pay Election to Discontinue or Waiver Request

Name:	Social Security Number:
Spouse/Registered Domestic Partner (RDP) Name:	Social Security Number:
Address:	
City:	State: ZIP Code:

Part 1 – Discontinue Mandatory e-Pay Election or Temporary Waiver Request (check one box)

☐ I elect to discontinue making electronic payments because I have not made an estimated tax or extension payment in excess of $20,000 during the previous taxable year or my tax liability did not exceed $80,000 for the previous taxable year.

☐ I request a waiver from the mandatory e-pay requirement because the amounts paid were not representative of my tax liability, as explained below:

Part 2 – Permanent Physical or Mental Impairment – Permanent Waiver Request (refer to PAGE 2)

☐ I request a mandatory e-pay waiver because of a permanent physical or mental impairment. You must attach a completed and signed physician affidavit to this form (see PAGE 3).

☐ **Mandatory e-Pay Penalty Waiver**. Check this box if you want us to review your account for possible waiver of a mandatory e-pay penalty we previously assessed. **All** the following **must** apply:

- You received a mandatory e-pay penalty for payments you made **before** we approved your permanent physical or mental impairment request.
- The date on the Physician Affidavit of Permanent Physical or Mental Impairment (line 3) is **before** the penalty assessment.
- The statute of limitations for filing a claim for refund of the penalty is still open.

Part 3 – Signature (if the waiver request is for a joint return, both spouses/RDPs must sign this form)

Taxpayer Signature	Date	Telephone Number
Spouse/RDP Signature	Date	Telephone Number

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Physician Affidavit of Permanent Physical or Mental Impairment

Patient/Taxpayer – Your physician must complete this affidavit of your permanent physical or mental impairment. Send in the original affidavit signed by your physician. Keep a copy for your records.

Physician – Complete and sign the following:

Patient Information

Name:	Social Security Number:	
Address (number, street, room, or suite number):		
City:	State:	ZIP Code:

Physician Affidavit of Permanent Physical or Mental Impairment

Physician's Name:	Medical License Number:	
Physician's Business Address (number, street, room, or suite number):		
City:	State:	ZIP Code:

1. Please provide a description of the patient's permanent physical or mental impairment. (If you need additional space, attach a separate piece of paper.)

2. In your medical opinion, does the permanent impairment prevent the patient from using a computer? ☐ Yes ☐ No

3. To the best of your knowledge, when did the patient become permanently mentally or physically impaired and become unable to use a computer? ____ /____ /_____

Signature

The patient named above is/was under my care. I completed the above information and declare this statement to be true and correct to the best of my knowledge and belief under penalty of perjury.

Physician's Signature _____ Date _____