Government of the District of Columbia

2007 D-2440 Disability Income Exclusion

0 7 2 4 0 0 1 1 0 0 0 0

Important: Print in CAPITAL letters using black ink.
Leave lines blank that do not apply.

OFFICIAL USE ONLY

Name as shown on Form D-40 | *Your social security number*

Personal information

Date of your birth (MMDDYY) | Date you retired (MMDDYY) | Name of your employer | Payor, if other than employer

Date of spouse's/domestic partner's birth(MMDDYY) | Date retired (MMDDYY) | Name of employer | Payor, if other than employer

Have you filed a physician's certification for this disability in previous years? Yes No

If *yes*, you do not have to file another certification. If *no*, you must file the physician's certification provided below.

Income

If married or registered domestic partners, use both columns. Round cents to the nearest dollar. If amount is zero, leave the line blank.

		You	*Your spouse*
1	**Total amount of disability payments received in 2007**	1 $ .00	$ .00
2	Multiply $100 by the number of weeks you claimed disability payments in 2007. If you received pay for part of a week, see the line 2 instructions on the back.	2 $ .00	$ .00
3	Enter Line 1 or Line 2 amount, whichever is less.	3 $ .00	$ .00
			Total income
4	*Add the amounts for you and your spouse from Line 3.*		4 $ .00

Limitation on exclusion

5	**Federal adjusted gross income** *from Form D-40, Line 3.*	5 $ .00
6	**Taxable social security income** *from Form D-40, Line 9.*	6 $ .00
7	Subtract Line 6 from Line 5.	7 $ .00
8	Amount used to reduce disability income.	- 1 5 0 0 0.00
9	Subtract Line 8 from Line 7. If zero or a negative number, stop here. Do not file this form.	9 $ .00
10	**Disability income exclusion** Subtract Line 9 from Line 4.	10 $ .00

Enter on D-40 Schedule I, Calculation B, Line 2 (see D-40 instructions). The exclusion may not exceed $5200 per disabled person.

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2007 Physician's Certification of Permanent and Total Disability

Name of disabled | Social security number

I certify that the above taxpayer was permanently and totally disabled on the date the taxpayer retired. (Enter the date retired.) MM DD YY

Physician's first name, middle initial, last name

Physician's address (number and street) | Suite number

City | State | Zip Code + 4

Physician's phone number | Physician's signature | Date

Attach to Form D-40. See instructions on back.