RA-923 10/86

REQUEST FOR MAILING OF DUPLICATE TAX BILLS OR STATEMENTS OF UNPAID TAXES TO A THIRD PARTY

Mail to:

(Tax Collecting Officer's Name and Address)

A. I request that a duplicate of any tax bill or statement of unpaid taxes with respect to my property as described below be mailed to the person whom I have designated.

In making this request I understand that neither the tax collecting officer nor any other local government employee has any liability if for any reason the duplicate is not mailed to or not received by my designee.

1. your name (last name first)
2. mailing address
3. post office 4. state 5. zip code
6. property identification (as shown on assessment roll)
7. tax billing address (if different from #2, above)
8. signature / (date)

THIS SECTION TO BE COMPLETED BY THIRD PARTY

1. third party name (last name first)
2. mailing address
3. post office 4. state 5. zip code
6. telephone
7. third party signature / (date)

B. The applicant is:
(check one)

☐ at least 65 years of age

OR

☐ disabled.

If disabled, have physician complete section below, or if applicant is legally blind, you may substitute a certificate from the State Commission for the Blind.

PHYSICIAN'S CERTIFICATION OF

PHYSICAL OR MENTAL DISABILITY

1. Physician's name _____
2. Office address _____
3. New York State license no. _____ Date of issue _____
4. Patient's name _____
5. Patient's address _____
6. Does patient have a physical or mental impairment which substantially limits one or more major life activities (e.g., walking)?
_____ Yes _____ No

I certify that all statements made in this section are true and correct to the best of my knowledge and professional belief.

_____
Date

_____
Signature of Physician