



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)

[Empty box for Tax Collecting Officer's Name and Address]

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.

- I am: At least 65 years of age
- or
- Disabled

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

1. _____
Your name (last name first)

2. _____
Mailing address

_____ Zip code

3. _____
Property Identification no. (see tax bill or assessment roll)

4. _____
Tax billing address (if different from #2, above)

5. _____ Signature _____ Date

THIS SECTION TO BE COMPLETED BY THIRD PARTY

1. _____
Third party name (last name first)

2. _____
Mailing address

_____ Zip code

3. _____ Day telephone no. _____ Evening telephone no.

4. _____ Third party signature _____ Date

**PHYSICIANS' CERTIFICATION FOR APPLICATIONS MADE ON BEHALF OF
AGED OR DISABLED PERSONS**

Physician's name

New York State license no.

Date of issue

Physician's office address

Patient's name

Patient's address

Does patient have a physical or mental impairment which substantially limits on or more major life activities (e.g., walking)?
____ Yes ____ No

Describe: _____

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