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)

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

RP-923 (1/95)

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 one 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