RP-923 (1/95)

New York State Board of Real Property Services

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

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