

## NEW YORK STATE DEPARTMENT OF TAXATION & FINANCE OFFICE OF REAL PROPERTY TAX SERVICES

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

Mail to:

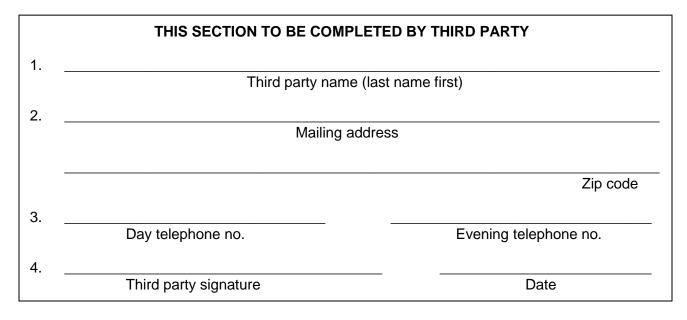
(Tax Collecting Officer's Name and Address) Receiver of Taxes, Henrietta 475 Calkins Road Rochester, NY 14623

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                                                |          |





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## 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:                               |                                            |                      |
|                                                  |                                            |                      |
|                                                  |                                            |                      |
|                                                  |                                            |                      |
| atient have a physical or mental imp<br>alking)? | pairment which substantially limits one or | more major life acti |
|                                                  |                                            |                      |
| 9:                                               |                                            |                      |
|                                                  |                                            |                      |
|                                                  |                                            |                      |

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