



**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)

Rebecca Valree
Fallsburg Town Clerk
 P.O. Box 2019
So. Fallsburg, NY 12779
 845-434-8810

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.

The applicant is:

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.	<hr/> Your name (last name first)	
2.	<hr/> Mailing address	
	<hr/> Zip code	
3.	<hr/> Property Identification no. (see tax bill or assessment roll)	
4.	<hr/> Tax billing address (if different from #2, above)	
5.	<hr/> Signature	<hr/> Date

THIS SECTION TO BE COMPLETED BY THIRD PARTY

1.	<hr/> Third party name (last name first)	
2.	<hr/> Mailing address	
	<hr/> Zip code	
3.	<hr/> Phone no.	
4.	<hr/> Third party signature	<hr/> 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 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 _____