



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.	_____ 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.	_____ Phone 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

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