



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

RP-923 (1/95)

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
3.	Property Identification no. (see tax bill or assessment roll)
4.	Tax billing address (if different from #2, above)
5.	Signature
	Date

<b>THIS SECTION TO BE COMPLETED BY THIRD PARTY</b>	
1.	Third party name (last name first)
2.	Mailing address
	Zip code
3.	Day telephone no.
	Evening telephone no.
4.	Third party 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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