

THIRD PARTY NOTIFICATION

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

MAIL THIS FORM TO:

**RECEIVER OF TAXES
VILLAGE OF TUCKAHOE
65 MAIN STREET
TUCKAHOE, NY 10707**

Part A.

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 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.

-
1. _____
Your Name (last name first)
 2. _____
Mailing Address
 3. _____ 4. State _____ 5. Zip Code _____
 6. _____
Property Identification (As Shown on Assessment Roll)
 7. _____
Tax Billing Address (If Different from #2, Above)
 8. _____
Signature _____ Date _____

THIS SECTION TO BE COMPLETED BY THIRD PARTY

1. _____
Your Name (last name first)
 2. _____
Mailing Address
 3. _____ 4. State _____ 5. Zip Code _____
 6. _____
Telephone _____
 7. _____
Third Party Signature _____ Date _____
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Part B.

The applicant is: (Check one)

_____ At least 65 years of age

OR

_____ Disabled

If disabled, have physician complete section below, or if applicant is legally blind, you may substitute a certificate from the State Commission for the Blind.

PHYSICIAN'S CERTIFICATION OF PHYSICAL OR MENTAL DISABILITY

1. Physician's Name: _____
2. Office Address: _____
3. New York State License No. _____
4. Date of Issue: _____
5. Patient's Name: _____
6. Patient's Address: _____
7. 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