RP-923 (1/95)

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)

Inc. Village of Rockville Centre
Tax Office
1 College Place
New York, NY 11570

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

THIS SECTION TO BE COMPLETED BY THIRD PARTY

1. _____
Third party name (last name first)

2. _____
Mailing address

_____
Zip code

3. _____ _____
Day telephone no. Evening telephone no.

4. _____ _____
Third party signature Date

RP-923 (1/95)

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

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
_____	_____

INC VILLAGE OF ROCKVILLE CENTRE - TAX OFFICE

CHANGE OF:

OWNERSHIP ☐

OR

MAILING ADDRESS ONLY ☐

OR

WHO WILL PAY TAXES ☐

Section _____

Block _____

Lot _____

Name on Deed _____

Property Location _____

Who Will Pay the Tax Bill? Owner ☐ Bank ☐ (Bank must notify us directly of their mailing requirements)

IF OWNER, PLEASE PROVIDE A VALID MAILING ADDRESS

_____

_____

Date of Change _____ _____

Signature

Return completed form to:

Inc Village of Rockville Centre
Tax Office
One College Place - PO Box 950
Rockville Centre NY 11571-0950