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

<u>A.</u>

Mi	ail to:	productive-associations		·					
О	ax Colle fficer's nd Addr	Name	÷						
I r my prop	request erty as	that a duplicate of described below be	f any tax mailed t	bill or sta o the pers	tement of on whom I	unpaid taxes have designat	with respect to		
otner to	car gov	this request I un ernment employee received by my de	: has any	that neit liability	her the ta if for any	nx collecting reason the d	officer nor any Iuplicate is not		
ł		\	Andrew Control of the		<u> </u>		***************************************		
İ	1.	your name (last n	iame first	.)			man or dar studen		
	2.	mailing address							
	3.	post office	4.	state	5.	zip code	to river a south		
79	6.	property identification (as shown on assessment roll)							
	7.	tax billing addres	s (if diffe	erent from	#2, above)	ant-review		
	8.	signature	harren militaria - Stadio America di Alfredo approvida per 11,2	garagal er kleffe-kall ann sinne sinlengt (george), syndasteryng	The Warman and Administration of the American Section 2018	/ (date)			
 		######################################					·		
		THIS SECTI	ON TO B	E COMPLI	ETED BY T	THIRD PARTY	<u> </u>		
	1.	third party name	(last nam	e first)	n, a ga a gan 1964 (aka ak a saisina dan pakal	and the same of the same and the			
	2.	mailing address	MANAGAMAN P. S.	District in the State of the St	distribution of the state of th	Man Nigerichtungsmeilen und der Mannethalten der Schreiber			
	3.	post office	4.	state		zip code			
	6.	telephone	way pi wan an a		And the state of t				
	7.	third party signa	ture	431m 14.9416/m 1961m (3415 14 14 14 14 14 14 14 14 14 14 14 14 14		/ (date)			

<u>в.</u>	The applicant is: (check one)	
	at least 65 years of age	
	OR	
	disabled.	
	If disabled, have physician complete section below, or if applicant is legal blind, you may substitute a certificate from the State Commission for the Blind.	ly
	PHYSICIAN'S CERTIFICATION OF	
	PHYSICAL OR MENTAL DISABILITY	
1.	Physician's name	
2.	Office address	
3.	New York State license no Date of issue	
4.	Patient's name	
5.	Patient's address	
6.	Does patient have a physical or mental impairment which substantially limits one or more major life activities (e.g., walking)? Yes No	
my	I certify that all statements made in this section are true and correct to the best nowledge and professional belief.	of
-	Date Signature of Physician	