CONSTITUTIONAL TAX COLLECTOR
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PBCTC Form 49 Rev.6/29/2018

PALM BEACH COUNTY LOCAL BUSINESS TAX FEE EXEMPTION APPLICATION

All information is required to process your exemption application. First time applicants are required to complete an Application for Palm Beach County Local Business Tax Receipt Form 65 in addition to this form.

Reason for Filing (check one):

- ☐ Honorably discharged veteran
- ☐ Spouse of honorably discharged veteran
- ☐ Un-remarried surviving spouse of honorably discharged veteran
- ☐ Spouse of certain active duty military service member who relocated to the county pursuant to a permanent change of station order
- ☐ Disabled person **(please have reverse side completed by a physician)**
- ☐ Widow with minor dependent(s)
- ☐ Person 65 years of age or older
- ☐ Low income individuals receiving public assistance **(re-evaluated yearly)**
- ☐ Low income individuals with a household income less than 130 percent of the federal poverty level based on the current year's federal poverty guidelines

Mail Exemption Application to:

Tax Collector,
Palm Beach County
P.O. Box 3353
West Palm Beach, FL
33402-3345

*Starred Fields are Required

*Business Name/Organization/Entity:_____

*Business Address:_____

*City:_____ State:_____ ZIP Code:_____

Mailing Address (if different from above):_____

City:_____ State:_____ ZIP Code:_____

Local Business Tax Receipt # (if applicable):_____

*Federal Employer Identification Number (FEIN):_____ or Social Security Number:_____

*Contact Person:_____ Title/Relationship:_____

*Phone:_____ Alternate Phone:_____

*Email:_____

I hereby attest that I am authorized to sign on behalf of the applicant / organization or entity described above. I further attest that if granted, this exemption will only be used in the manner authorized under the provisions of Chapter 205 of the Florida Statutes.

Under penalties of perjury, I declare that I have read the foregoing application and that the facts stated and attached herein are true.

_____ Print Name

_____ Title/Relationship

_____ Signature

_____ Date

PHYSICIAN'S CERTIFICATE FOR DISABLED PERSONS

STATE OF FLORIDA COUNTY OF _____

I, _____, hereby certify that I am a licensed practicing physician, located at _____, Florida, and I am personally acquainted with _____ who is an applicant for the exemption from payment of business tax under the provisions of Chapter 205 of the Florida Statutes, and that on (MM/DD/YYYY)_____

I have thoroughly examined the said applicant and found him/her to be physically disabled. The nature and extent of the applicant's disability are as follows:

_____

_____

_____

_____

_____

_____
Phone Number

_____

_____
Print Physician's Name

_____
Address

_____
Physician's Signature

_____
Date