DIRECTOR OF CORPORATE SERVICES
REVENUES DIVISION
PO BOX 216
DUNDEE
DD1 3YJ
TELE: (01382) 431205
FAX: (01382) 431383

If you encounter any difficulty reading this form please contact the address or telephone number given opposite

LOCAL GOVERNMENT FINANCE ACT 1992
APPLICATION FOR COUNCIL TAX PERSONAL DISCOUNT ON THE GROUNDS OF SEVERE MENTAL IMPAIRMENT

Account No ____________________ **Property Reference No** ____________________

Applicants Name ____

Applicants Address ____

____

____

TO BE COMPLETED BY THE REGISTERED MEDICAL PRACTITIONER

Doctors Name ____

Surgery / Hospital Address ____

____

____

Please tick the appropriate box
I certify that, in my opinion the applicant named above

Is ☐

Is Not ☐

suffering from severe impairment of intelligence and social functioning (however caused) which appears to be permanent, as defined in paragraph 2 of schedule 1 to the Local Government Finance Act 1992.

PLEASE CONFIRM THE EXACT DATE FROM WHICH THE ABOVE NAME WAS DIAGNOSED: _____/_____/_____

Doctor's Signature ____

Doctor's Full Name (BLOCK CAPITALS) ____

Doctor's Status ____

Date ________________