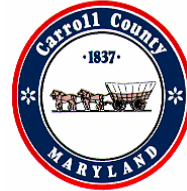


CARROLL COUNTY OFFICE OF PUBLIC SAFETY SUPPORT SERVICES



"A GREAT PLACE TO LIVE, A GREAT PLACE TO WORK, A GREAT PLACE TO PLAY"

**225 N. CENTER ST., WESTMINSTER, MD 21157
410-386-2296, Fax: 410-848-3794**

August 3, 2006

Carroll County Residents with Disabilities,

In an effort to better serve you during an emergency or disaster, we are asking for your assistance. The following form will allow us to recognize our resident's special needs and prepare for future emergencies.

Although completion of this form is voluntary, the more information you provide to the Office of Public Safety Support Services the better we will be able to assist you during an emergency or disaster. The information you provide will be kept strictly confidential. Therefore, this form is not subject to the Maryland Public Information Act. Your information will be managed by our Emergency Management Team.

If Carroll County is struck by a disaster that severely impacts our residents, your information will be disclosed to emergency personnel only so that they may assist you and attend to your needs.

Thank you for assisting us in making Carroll County a safer place to live. If you have any questions regarding this form or the registration process, please contact Ms. Christina Calp, Emergency Management Specialist, at 410-386-2296.

Sincerely,

Scott R. Campbell, Administrator
Office of Public Safety Support Services



Carroll County Maryland Registration for Residents with Disabilities

New Registration Updated Registration Today's Date: _____

PERSONAL INFORMATION

Name of Individual with Disability: _____

Last

First

Middle

Street Address: _____

Street

Apt #/P.O. Box

City

Zip

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____ Pager: _____

Email: _____

Date of Birth: _____

Sex: M F

Language Spoken: _____ Height: _____ Weight: _____

Residence Type: House/Duplex Mobile Home/Trailer Apartment/Condo

Name of Mobile Home/Manufactured Home Park or Apartment Building:

Living Situation: Living Alone With Family With Non-Relative

CARE REQUIREMENTS/DISABILITY (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Medical Dependence on Electricity | <input type="checkbox"/> Mental Impairment |
| <input type="checkbox"/> O2 Concentrator, Nebulizer | <input type="checkbox"/> Alzheimer's/Dementia |
| <input type="checkbox"/> Feeding Pump | <input type="checkbox"/> Respirator Dependent |
| <input type="checkbox"/> Suction | <input type="checkbox"/> Bedridden |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Speech Impairment |
| <input type="checkbox"/> Wheelchair User | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Walker/Cane User | <input type="checkbox"/> Service Animal |
| <input type="checkbox"/> Cognitive Impairment | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Dialysis Dependent |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Morbid Obesity | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Assistance with Administration of Medications | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Medications: _____ | |

REQUIRED ASSISTANCE

Will your personal assistant be accompanying you? Yes No

Assistant's Name: _____ Phone Number: _____

Is transportation needed? Yes No
Type: Automobile Van with wheelchair lift Ambulance

PET INFORMATION (if applicable, indicate how many)

____ Cat ____ Dog ____ Service Dog ____ Other: _____

EMERGENCY CONTACT INFORMATION

(Local) Name: _____ Phone: _____ Relation: _____

(Non-local) Name: _____ Phone: _____ Relation: _____

Physician: _____ Phone: _____

Home Health Care Agency: _____ Phone: _____

Oxygen Provider: _____ Phone: _____

AGREEMENT

I understand that completion of this form is merely to assist with an emergency response and in no way guarantees an emergency response or special priority during an emergency or disaster. I understand in the event of an emergency or disaster, if I need assistance, Carroll County Emergency Management will prioritize use of pertinent County resources in accordance with County policy. Therefore, I give Carroll County Emergency Management authorization to share this information with other local support agencies in the event of an emergency or disaster. I also grant emergency response personnel permission to enter my home during search and rescue operations following a disaster, if necessary, to assure my safety and welfare.

If at any time a change is made to the above information, please send an updated form to the Office of Public Safety Support Services.

Type/Print Name: _____

Person Completing Form (Care Taker): _____

ASSISTANCE

If you need assistance or have any questions regarding the registration please feel free to contact Christina Calp at 410-386-2296.

If Mailing Send To:

Office of Public Safety Support Services
Attn: Christina Calp
225 North Center Street
Westminster, MD 21157