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 REQUIRMENTS/DISABILITY (check all that apply):

☐Medical Dependence on Electricity
- ☐02 Concentrator, Nebulizer
- ☐Feeding Pump
- ☐Suction
- ☐Other:_________________

☐Assistance with Administration of Medications
☐Wheelchair User
☐Walker/Cane User
☐Cognitive Impairment
☐Anxiety/Depression
☐Other:______________________________

☐Mental Impairment
☐Alzheimer's/Dementia
☐Respirator Dependent
☐Bedridden
☐Speech Impairment
☐Visual Impairment
☐Hearing Impairment
☐Service Animal
☐Incontinence
☐Dialysis Dependent
☐Allergies:______________________________

☐Emphysema
☐Heart Disease
☐Stroke
☐Cancer
☐Morbid Obesity

☐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