

**TOWNSHIP OF DENNIS  
OFFICE OF EMERGENCY MANAGEMENT  
P.O BOX 204, 571 PETERSBURG ROAD  
DENNISVILLE, NJ 08214**

**Emergency & Special Needs Registration Form**

**NAME OF PERSON WITH SPECIAL NEEDS:**

NAME: \_\_\_\_\_ PHONE#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**DESCRIPTION OF SPECIAL NEEDS:**

<input type="checkbox"/> BED RIDDEN	<input type="checkbox"/> HEARING IMPAIRED	<input type="checkbox"/> SPECIAL MEDICATIONS
<input type="checkbox"/> BLIND	<input type="checkbox"/> LANGUAGE BARRIOR	<input type="checkbox"/> TTY/TDD
<input type="checkbox"/> DIABETIC	<input type="checkbox"/> OTHER SPECIFY	<input type="checkbox"/> USES SEEING EYE DOG
<input type="checkbox"/> DIAIYSIS PATIENT	<input type="checkbox"/> OXYGEN	<input type="checkbox"/> WHEELCHAIR BOUND

**ADDITIONAL INFORMATION:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**SPECIAL INSTRUCTIONS:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**INDIVIDUAL COMPLETING FORM:**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE#: \_\_\_\_\_

WORK PHONE#: \_\_\_\_\_

EMAIL: \_\_\_\_\_

DATE: \_\_\_\_\_

**THE INFORMATION CONTAINED ON THIS SPECIAL NEEDS FORM MAY INVOLVE PERSONAL MEDICAL INFORMATION WHICH IS NOT SUBJECT TO THE STATE RIGHT-TO-KNOW LAWS. THE INFORMATION ON THIS FORM IS CONSIDERED PERSONAL AND PRIVATE AND IS PROVIDED FOR THE SOLE PURPOSE OF DEVELOPING A SPECIAL NEEDS DATABASE TO BE UTILIZED BY THE TOWNSHIP OF DENNIS OFFICE OF EMERGENCY MANAGEMENT, AND/OR ANY OF ITS DESIGNATED AGENTS ASSOCIATED WITH THE 9-1-1 DISPATCH CENTER.**