



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

2009 SPECIAL NEEDS FORM

NAME OF PERSON WITH SPECIAL NEEDS:

NAME: _____ PHONE#: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DESCRIPTION OF SPECIAL NEEDS:

___ WHEELCHAIR BOUND ___ DIALYSIS PATIENT ___ DIABETIC

___ HEARING IMPAIRED ___ TTY/TDD ___ SPECIAL MEDICATIONS

___ OXYGEN ___ BLIND ___ USES SEEING EYE DOG ___ LANGUAGE BARRIER

ADDITIONAL INFORMATION:

1. _____

2. _____

3. _____

SPECIAL INSTRUCTIONS:

1. _____

2. _____

3. _____

INDIVIDUAL COMPLETING FORM:

NAME: _____ PHONE#: _____

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.