HANNA MARSHALS OFFICE

TELEPHONE REASSURANCE PROGRAM

Participant Application

Name:	Date:	
Street:	Phone:	
City:	Birth Date: Age:	
State: Zip:	Sex:	
INFORMATION		
I live alone:	If no, spouse or other:	
Circle yes or no YES NO		
Do you have a vehicle: Circle yes or no YES NO	If yes please give info. Year: Make: Model: Color: Lic. plate# State:	
Primary Physician:	Office Number:	
Hospital you perfer:	Hospital Number:	
Do you own a pet: YES NO	Pets Name:	
How many? Cats DogsEtc		
Is your pets confined to a room: YES NO	Which Room:	
Who will take care of pets if hospitalized: Name:	Phone:	
Are you confined to a room: YES NO	If yes which room:	
Are you able to walk unassisted: YES NO	If no, what do you use, Please Circle: Cane Walker Wheelchair	
MEDICATIONS&HISTORY		
	If yes, where is the list:	
Do you have a list of meds. YES NO		
,	If yes, please list:	
Do you have any allergies: YES NO		
Please list any other info. That you		
you would like us to know.		

EMERGENCY CONTACTS	
Do you have a neighbor or friend nearby	
That you have designated as a contact:	Please circle one: YES NO
Name:	
Address:	
Phone:	
Cell:	
Do any of your Contacts have a key to your home:	If Yes,Name:
Please circle one: YES NO	Phone:
Contact # 1:	Phone: Home:
Name:	Work:
Address:	Cell#
Relationship:	
Contact # 2:	Phone: Home:
Name:	Work#:
Address:	Cell#
Relationship:	

In requesting to become a particpant, I understand that this information including any medical information that I wish to disclose, may be shared with the Hanna Marshals Office, Carbon County Ambulance (S.W.E.M.S.), Carbon County Sheriff's Office and Carbon County Fire Department.

This program is voluntary and I am consenting to allow the Agencies listed above to have this information indicated on the Participant Application. I understand that I may cancel this program at any time. There is no cost for this program.

SIGNATURE: _____

DATE:	 _