



9-1-1

MEDICAL NEEDS / INFORMATION

PURPOSE: To inform 9-1-1 of my medical needs, disabilities, and other information to help rescuers and dispatchers get me the appropriate help. This information will be available when my phone number dials 9-1-1 for assistance, and in the event of an emergency or disaster, will aid rescuers in prioritizing emergency services.

NAME: _____ **TELEPHONE#:** _____

911ADDRESS: _____ **TOWN:** _____

MEDICAL CONDITION: _____

MEDICAL EQUIPMENT NEEDS: _____

EQUIPMENT THAT IS ELCTRICALLY DEPENDENT: _____

DO YOU HAVE AN EMERGENCY GENERATOR? _____

HOW MANY HOURS OF BATTERY LIFE DOES YOUR DEVICE POSSESS? _____

HOW MANY DAYS OF OXYGEN OR OTHER VITAL SUPPLY DO YOU POSSESS? _____

THANK YOU FOR MAKING THIS INFORMATION AVAILABLE TO RESCUERS AND EMERGENCY PERSONNEL. I GIVE PERMISSION FOR THIS INFORMATION TO BE POSTED FOR MY NAME, ADDRESS, AND PHONE NUMBER.

SIGNED : _____

DATE : _____

SEND FORM TO:

**OFFICE of EMERGENCY SERVICES
71 RESERVOIR ROAD, HERKIMER, N.Y. 13350
TELEPHONE: 866 - 0974 FAX: 867 – 5873**

911 INFO REQUEST FORM APPROVAL PAGE

APPROVAL	DATE	APPROVAL	DATE