

PARAMUS EMERGENCY SERVICES
SPECIAL NEEDS REGISTRATION FORM

Name of Applicant: _____

Address: _____

Telephone Number(s): 1. _____ 2. _____

Email Address: _____

Age: _____ Sex: Male / Female (Circle One)

Emergency Contact Information:

Name: _____

Address: _____

Telephone Number(s): 1. _____ 2. _____

Relationship: _____

Describe Illness or Ailment:

Check ONLY if it applies to applicant:

- | | |
|---|--|
| <input type="checkbox"/> Bed ridden - Room location: _____ | <input type="checkbox"/> Home Infusion Pump |
| <input type="checkbox"/> Use of Oxygen | <input type="checkbox"/> Vision Impaired / Blind |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Hearing Impaired / Deaf |
| <input type="checkbox"/> Inability to walk? ___ Wheelchair? _____ | <input type="checkbox"/> Other: _____ |

Name of Person submitting form: _____

Address: _____

Telephone Number(s): 1. _____ 2. _____

Relationship to applicant: _____

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**For Office Use ONLY:**

Date Received: \_\_\_\_\_ Date of Entry: \_\_\_\_\_

Received By: \_\_\_\_\_ Entered By: \_\_\_\_\_

Please forward completed forms to: Paramus Emergency Management, 1 Jockish Square, Paramus, NJ 07652