

**PEOPLE WITH SPECIAL NEEDS
VOLUNTEER REGISTRATION REQUEST**

Union County Emergency Management
Special Needs Registry

Date of Registration: _____

Do Not Write above This Line

Name: _____ Age: _____

Physical Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Mailing Address: (if different from above) _____

Primary Language: _____

Emergency Contact Person: _____

Phone: _____ Cell Phone: _____

Check applicable medical disabilities:

- Ambulatory Yes No
- Bedridden Yes No
- Ambulatory w/assist Yes No
walker, cane, wheelchair, etc.
- Non-ambulatory Yes No
- Hearing Impaired
- Vision Impaired
- Speech Impaired
- Contagious Disease

Specify other disabilities: _____

Check if you require the following:

- Life Support Dialysis
- Insulin IV Fluids
- Feeding Tube Suction Unit
- Special Diet (if so what type) _____
- Oxygen (if so # hours daily _____)
- Do you have a portable tank Yes No
- Do you use a concentrator Yes No
- Require a 24hr caregiver Yes No

Primary Care Physician: _____ Phone: _____

Home Health Care Provider: _____ Phone: _____

Pharmacist: _____ Phone: _____

- Can you get to an evacuation shelter? Yes No
If no, check the appropriate transportation type needed:
 Standard Vehicle Wheelchair equipped Ambulance

Will a caregiver accompany you to an evacuation shelter? Yes No

I certify that the above information is correct. I understand that I am responsible for all expenses associated with medical evacuation and shelter at a hospital. I hereby grant permission to Union County Emergency Management to release this information to other emergency response agencies.

Signed: _____ Date: _____

Mail completed form to:
Union County Emergency Management
Attn: Special Needs Database
500 North Main Street
Monroe NC 28112

Or Fax to 704-283-3716