SPECIAL NEEDS REGISTRY PROGRAM REGISTRATION FORM

Return Completed Form to:
Marion County Emergency Management
P.O. BOX 1987
Ocala, Florida 34478
Office: (352) 369-8100 Fax: (352) 369-8101

Personal Information			
Last Name:	First Name:	Birth Date:	Sex ☐ M ☐ F Weight:_____ Primary Language:
Address:			Apartment/Unit#:
City:	Zip:	Name of Complex/Subdivision:	
Type of Residence: ☐ Single Family Home ☐ Apartment/Condo ☐ Mobile Home/Manufactured Home			
Home Phone:	Mobile Phone:	Email Address:	
Home Health Agency Name and Phone Number:			
Emergency Information			
Living Status: ☐ Alone ☐ With Relative ☐ With Caregiver ☐ Other(please indicate):			
Local Emergency Contact Name and Number:			
Non-Local Emergency Contact Name and Number:			
Will you have a companion/caretaker accompanying you to the evacuation location? ☐ Yes ☐ No			
• If Yes, Companion Name:		Companion Phone:	
Client Information			
Do you use oxygen?	☐ Yes (☐ Intermittent ☐ Continuous) ☐ No		
• If Yes, Oxygen Provider:		Phone:	
Do you use medical equipment that requires electricity to operate? ☐ Yes ☐ No			
• If Yes, specify the equipment that requires electricity:			
Do you use medication that required refrigeration?	☐ Yes ☐ No		
Are you memory impaired?	☐ Yes ☐ No		
Do you receive dialysis?	☐ Yes ☐ No		
Are you confined to a bed?	☐ Yes ☐ No		
Do you require a Hoyer lift to transfer?	☐ Yes ☐ No		
Do you have a service animal?	☐ Dog ☐ Miniature Horse ☐ No		
Do you have any domestic pets?	☐ Yes ☐ No		
• If yes, list types and how many:			
Mobility Device?	☐ Yes (☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Walker) ☐ No		
Do you require transportation to a shelter?	☐ Yes ☐ No		
If yes, do you require ADA/Wheelchair lift?	☐ Yes ☐ No		
Do you have a DNR order?	☐ Yes ☐ No		
Office Use Only			
☐ SpNS ☐ Transportation Only ☐ Beyond Care ☐ Not Applicable			

By signing up for the Special Needs Registry Program, you are acknowledging that you have read, understood, and agree with the Notice of Privacy Practices for Protected Health Information