

**Return to: Montgomery Township Local Emergency Planning Council**  
c/o Stephanie Carey, Health Officer – Montgomery Township Health Department – 908-359-8211  
2261 Route 206  
Belle Mead, NJ 08502

**Emergency Outreach Registration Request**

I am a Montgomery Township resident, and I (or the minor identified below who is a resident in my household) have a medical or physical condition that I believe may place me or the minor listed below at particular risk if a power failure or other general emergency circumstance occurs in the Township. Therefore, I hereby request that the Montgomery Township Health Department and its designated Township staff retain this form so that the information I am providing will be available to police and emergency medical services in the event of a power failure or other emergency. I understand that the information I am providing will be retained in confidential files in the records of the Montgomery Township Health Department and will be used only in the event of a power failure or other emergency circumstance, or in preparedness training for such circumstances. I further understand that this Registration will be used to assist emergency personnel but does not guarantee any particular level of services in an emergency.

**Name of Person at Risk:** \_\_\_\_\_  
(Please Print)

**If person is under age 18,**  
**Name of parent or guardian signing this request:** \_\_\_\_\_  
(Please Print)

**Full Address:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Phone(s): Home** \_\_\_\_\_ **Mobile:** \_\_\_\_\_ **Other:** \_\_\_\_\_

Does person live alone? Yes \_\_\_ No \_\_\_

Is there medical equipment in the home that runs on electric power? Yes \_\_\_ No \_\_\_

Does the person rely on electric-powered devices to aid breathing? Yes \_\_\_ No \_\_\_

(Optional) Brief description of the medical or physical condition and/or any comments which might be helpful to police or emergency services: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person to call if we are unable to reach the person at risk in the event of emergency. (Someone most likely to know the party's whereabouts.) :

Name \_\_\_\_\_ Phone(s) \_\_\_\_\_

I certify that I have received a copy of the *Notice of Privacy Practices of the Montgomery Township Health Department*.

**NOTE: IT IS EXTREMELY IMPORTANT THAT YOU NOTIFY STEPHANIE CAREY, HEALTH OFFICER AT THE HEALTH DEPARTMENT AT 908-359-8211 IF THERE ARE ANY CHANGES TO THE INFORMATION PROVIDED ABOVE.**

**Signature of Person at Risk** (or parent or guardian, if a minor): \_\_\_\_\_  
Date signed: \_\_\_\_\_