



Lavallette Police Department Operation Reassurance Program Application

Name: _____ Phone # _____

Address: _____

Religion: _____

Do you have a Living Will/Advance Directive? []YES []NO

Power of Attorney? Name _____ Phone#: _____

Relative or Friend to be notified in case of any emergency:

Name: _____ Relationship: _____

Phone #: _____

Are you considered handicapped or an invalid? YES NO

If yes, please explain: _____

Key Information:

Do you wish to leave a key at Police Headquarters? YES NO

Does a neighbor have a key? YES NO

If yes, Name: _____ Phone # _____

Address: _____

Vehicle Information:

Make: _____ License Plate #: _____ Year: _____

Color: _____ Where usually parked? _____

Signature: _____ Date: _____

Medical Information:

Doctor's Name: _____ Phone # _____

Address: _____

Do you have any of the following impairments?

Vision: _____ Glasses? _____ Dentures? _____

Hearing _____ Aid (R) _____ (L) _____

Mobility Impaired? Explain: _____

Have you ever been treated for any of the following:

- High Blood Pressure Diabetes Heart Disease Stroke
- Migraine Headaches Seizures Alcoholism Back Injuries
- Phlebitis Asthma Tuberculosis Gastro-Intestinal Disease
- Hepatitis Hernia Mental Illness Varicose Veins
- Pneumonia Cancer Anemia Dermatitis(skin rash)
- Kidney Disease Arthritis Glaucoma Venereal Disease

Surgical History:

Year	Type	Year	Type

Allergies: _____

Current Medications

Medication	D ose	Purpose