



# 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