

FORT LEE FIRE DEPARTMENT **INVALID LOCATION PROGRAM**

1. THIS FORM MUST BE COMPLETED IN FULL AND SUBMIT PAGES 2 – 4
TO: FORT LEE FIRE DEPARTMENT
309 MAIN STREET
FORT LEE, NJ 07024
ATTN: INVALID REGISTRATION
2. ONCE COMPLETED AND SUBMITTED, THE PERSON SUBMITTING THIS FORM WILL BE CONTACTED TO VERIFY ALL OF THE INFORMATION
3. AS PART OF THE PROGRAM, AN IDENTIFICATION STICKER WILL BE MAILED TO THE INDIVIDUAL SUBMITTING THE FORM WITH INSTRUCTIONS ON WHERE TO PLACE THE STICKER
4. THIS PROGRAM IS ONLY FOR THOSE WHO LIVE OR WORK IN FORT LEE. *** IT CAN NOT BE USED IN ANY OTHER TOWN ***
5. ALL OF THIS INFORMATION IS STRICTLY CONFIDENTIAL AND IS ONLY FOR THE USE BY THE FORT LEE FIRE DEPARTMENT IN CASE OF AN EMERGENCY
6. THIS PROGRAM IS FOR INDIVIDUALS OF ALL AGES WITH ANY TYPE OF DISABILITY, EITHER TEMPORARY OR PERMANENT, THAT WOULD PREVENT THEM FROM EVACUATING THE BUILDING ON THEIR OWN
7. IF THE INDIVIDUAL WHO IS BEING REGISTERED MOVES OR IS NO LONGER EMPLOYED AT THE ADDRESS SUPPLIED OR IF THE DISABILITY CHANGES, PLEASE CONTACT THE DEPARTMENT IMMEDIATELY SO THAT WE CAN REMOVE THE INDIVIDUAL FROM THE PROGRAM. ONCE THIS IS COMPLETED, THE IDENTIFICATION STICKER MUST BE REMOVED FROM ITS LOCATION

FORT LEE FIRE DEPARTMENT INVALID LOCATION PROGRAM

NAME _____

ADDRESS _____

AGE _____ **MALE** _____ **FEMALE** _____

PHONE _____

CONDITION OF DISABILITY: TEMPORARY _____ **PERMANENT** _____

TYPE OF DISABILITY _____

MEDICATION(S) NEEDED? YES _____ **NO** _____

NAME OF MEDICATION(S) _____

LOCATION OF MEDICATION: BEDROOM _____ **BATHROOM** _____

KITCHEN _____ **OTHER** _____

ALLERGIES _____

SPECIAL DEVICES NEEDED: WHEELCHAIR _____ **WALKER** _____

CRUTCHES _____ **CANE** _____ **STRETCHER** _____ **OXYGEN** _____

IF BEDRIDDEN, LOCATION OF BED:

BEDROOM____ **1st FLOOR**____ **2nd FLOOR**____ **3rd FLOOR**____

BASEMENT____

OTHER_____

DOCTOR INFORMATION

DOCTOR'S NAME_____

ADDRESS_____

PHONE_____

EMERGENCY CONTACTS

NAME_____

ADDRESS_____

PHONE_____

NAME_____

ADDRESS_____

PHONE_____

NAME_____

ADDRESS_____

PHONE_____

PERSON SUBMITTING FORM

NAME _____

ADDRESS _____

PHONE _____

RELATIONSHIP _____

SIGNATURE _____

DATE SUBMITTED _____

IF THIS IS FOR AN EMPLOYEE OF A COMPANY

COMPANY NAME _____

COMPANY ADDRESS _____

PHONE _____

EMPLOYEES NAME _____

EMPLOYEES WORK HOURS _____

LOCATION OF EMPLOYEE DURING WORK HOURS _____



FOR OFFICE USE ONLY

DATE FORM RECEIVED _____

RECEIVED BY _____

DATE OF ENTRY _____

ENTERED BY _____