Phyliss Leon Guerrero
Director

Daniel Stone
Fire Chief

APPLICATION FORM

A partnership between Department of Integrated Services for Individuals with Disabilities (DISID) and the Guam Fire Department (GFD)

Lourdes A. Leon Guerrero
GOVERNOR OF GUAM

Joshua F. Tenorio
LT. GOVERNOR OF GUAM

“Emergency On-Line Registry

WAIVER AND GENERAL RELEASE OF CONFIDENTIAL INFORMATION

I/We expressly understand and agree that under P.L. 33-54, the Guam Fire Department (GFD) in collaboration with the Department of Integrated Services for Individuals with Disabilities (DISID) has been mandated to create an online registry for persons with special needs to assist first responders such as police, fire fighters, paramedics, or emergency medical technicians to interact appropriately and effectively respond in the event of an emergency such as an accident, natural disaster, or terrorist attack. My information or that of a parent or guardian, family member, or ward may be included in the registry only by completing the attached form and providing the information to DISID or GFD.

DISID, the GFD and its officers, agents, representatives, and employees are not responsible for determining whether providing information is suitable for my parent or guardian, family member, ward, or me; only I will make that decision. All information will be kept confidential and voluntarily provided and it is the applicant’s responsibility to provide information that they feel is important to the Registry.

I, acknowledge that I am the authorized representative and can sign on behalf of an individual with special needs, a parent or guardian, family member, or ward as stated in a valid Power of Attorney or other such documents.

I also understand that police, fire, or other personnel will not supply a parent or guardian, family member, ward, or me with preferential consideration in an emergency because I completed and provided DISID and GFD the attached registration form.

I understand that by completing the attached registration form, I am providing health information to DISID and GFD. My signature below indicates the waiver of my right or the right of my parent or guardian, family member, or ward to the confidentiality of the information given to DISID and GFD.

I understand that DISID and GFD will keep the health information confidential and will use it only as permitted and necessary, which may include public health activities.

By signing below, I release and hold harmless on behalf of my parent or guardian, family member, ward, or myself, the Government of Guam, its agents, representatives, and employees from any liability or potential liability including but not limited to accidents, injuries, or death arising out of or related to the information I have provided on the attached form.

I have read this Waiver and General Release of Confidential Information and fully understand its terms and voluntarily accept them or accept them on behalf of my parent, family member, or ward.

I. PERSONAL INFORMATION:

Last Name: ______________________________ First Name: _______________________ Middle Initial: ______________

Gender: □ Male □ Female □ Transgender Height:__________ Weight:___________ Blood/RH Type: ____________

Eye Color:________________ Hair Color:________________ Birthmarks/Scars/Tattoos:____________________________

Date of Birth:____________________ Place of Birth:________________________ Marital Status:____________________

Ethnicity/Race:__________________________ Languages Spoken *(Primary/Secondary):* ____________________________

Do you need a Language Translator □ Yes □ No Do you need an ASL Interpreter □ Yes □ No

Please describe your communication methods and ways officers can best communicate and interact with you:

TTY: ____ VRS: ___________________ Text:___________________

Home Address/Apt./Room#: ____

Name of Complex/Subdiv./Apt./Facility:____ Is there an elevator?:________

Mailing Address: ____

Email Address: ____ Veteran: □ Yes □ No

(Note: Email Address is mandatory. If you don't have an email address, a DISID Social Worker will be able to provide you with assistance in setting up an email account).

Telephone (Home):_________________________ (Cell):________________________ (Work): _______________________

Healthcare Provider:_______________________________________ Member ID#: __________________________________

Caregiver or Advocate:_____________________________________ Contact Number: ____________________________

II. EMERGENCY CONTACT OR PARENT/GUARDIAN INFORMATION (If applicable):

Last Name: _____________________________ First Name: __________________________ Middle Initial:________

Gender: □ Male □ Female Relationship:______________ Email Address: _________________________________

Home Address: ____

Mailing Address: ____

Telephone (Home): _________________________

III. SPECIAL NEEDS / MEDICAL HISTORY INFORMATION:

Type of Disability: □ Blind/Low Vision □ Mobility Impairment □ Seizure □ Mental Health Condition

□ Memory Loss □ Speech Impairment □ Deaf/Hard of Hearing □ Developmental/Intellectual Disability

Assistive Devices: □ Wheelchair □ Scooter □ Walker □ Cane □ Crutches □ Prosthesis

□ Walking Stick □ Hearing Aid(s) □ Pacemaker □ Other:__________________ □ Service Animal: _________________

Electricity Dependent: □ Ventilator □ Home Oxygen System □ Other: ______________________________

Medical Needs: □ Medications □ Dialysis □ Feeding Tube □ Asthma Inhaler □ Diabetic

□ Allergies (allergic to):____ □ Other: ___________

Transportation: □ Iam self-ambulatory □ I am non-ambulatory and require stretcher transport

□ Ambulatory with assistance □ I need a wheelchair-lift vehicle

Other critical info or requirements: ____

_________________________________ Print Name

_________________________________ Signature

_________________ Date

_________________________________ Print Name of Parent or Guardian

_________________________________ Signature of Parent or Guardian

_________________ Date