



PICKENS COUNTY E-911 MEDICAL INFORMATION REQUEST

Name: _____ Home Phone #: _____

Address: _____

Description of medical problem and/or disability: _____

Medications: _____

Primary Care Physician: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

I AUTHORIZE THE PICKENS COUNTY E-911 OFFICE TO ADD THE ABOVE INFORMATION TO THEIR CAD SYSTEM TO MAKE IT AVAILABLE TO ANY EMERGENCY UNIT(S) RESPONDING TO 911 CALLS AT THE ABOVE ADDRESS. THIS WILL BE USED AS AN INFORMATION TOOL ONLY AND DOES NOT GUARANTEE RESPONSE TIMES, SERVICES, OR ACCEPTANCE OF LIABILITY BY PICKENS COUNTY OR ITS AGENTS.

I UNDERSTAND I AM RESPONSIBLE FOR UPDATING THIS INFORMATION EVERY SIX MONTHS. IN THE EVENT MY TELEPHONE NUMBER CHANGES OR IF I MOVE, I WILL NOTIFY THE E-911 OFFICE AT 898-5958.

Signature: _____ Relationship: _____

Received by: _____ Date: _____