

**City of Plymouth**

**Special Needs Voluntary Registration**

Resident Name: \_\_\_\_\_ Street Address: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Do you need assistance walking?  Walks unassisted  Walks with assistance

Wheelchair  Bed bound

If a disaster would require you to be evacuated, where would you stay?

Stay with family or others  Evacuate to a shelter

In case of an evacuation emergency, I hereby give emergency response personnel, law enforcement or human services agencies or officials permission to enter my home.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Return This Form To: **CITY OF PLYMOUTH  
PO BOX 278  
PLYMOUTH, IA 50464-0278**