Special Needs Information Participation Program

USE OF THIS FORM DOES NOT TAKE THE PLACE OF STANDARD INITIAL REQUESTS FOR EMERGENCY ASSISTANCE
You must still contact Emergency/911, Fire, Rescue services as normal for assistance.

Check One ☐ New Record ☐ Update Existing Record

Date/Time Field

Your Name And Address	Person To Contact In Case Of Emergency
Name:	Name:
Address:	Address:
City: State In City Limits? ☐ Yes ☐ No	City: State In City Limits? ☐ Yes ☐ No
Zip Code Phone (numbers only)	Zip Code Phone (numbers only)
Email:	Email:

Do you have a vehicle?
☐ Yes
☐ No

If you do not have a vehicle do you have someone who can pick you up?
☐ Yes
☐ No

Type of transportation needed:
☐ None
☐ Regular vehicle
☐ Wheelchair Assistance
☐ Ambulance

Special needs:
☐ Can't walk
☐ Confined to bed
☐ On oxygen
☐ Blind
☐ Mute
☐ Deaf
☐ Other:

Conditions of Use
Welcome to the EMA Special Needs Registry. Providing the required Special Needs health information subjects you to the following conditions. If you provide the information, you accept these conditions. Please read them carefully.

BY SUBMITTING SPECIAL NEEDS HEALTH INFORMATION I AM ACCEPTING THE FOLLOWING TERMS AND CONDITIONS REGARDING DISCLOSURE OF THE INFORMATION. THE INFORMATION GIVEN may include psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health information and I expressly consent to the release of this information. THE INFORMATION GIVEN may be released by the St. Clair County Emergency Management Agency (EMA), or the St. Clair County E-911 dispatcher to any First Responder, Emergency Medical personnel or volunteer agency during an emergency situation or for planning purposes. THE INFORMATION given may be used by emergency personnel to further assist citizens in the county with special needs during the time of an emergency. I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This authorization is valid until revoked by me. I understand I may revoke this authorization in writing at any time by completing a form available from the St. Clair County EMA. If I revoke this authorization (which must be in writing and received by EMA), the revocation will not apply to the information that has already been released in response to this authorization. I understand I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. I represent that I have the authority to and voluntarily grant permission for the information to be released as described above.

DISCLAIMER of warranties and limitation of liability of this site is provided by St. Clair County EMA on an "AS IS" and "AS AVAILABLE" basis. St. Clair County EMA/911 makes no representations or warranties of any kind, expressed or implied, from the information, content, or materials included on this form or of its use in this program. While EMA may periodically update the information provided by or on behalf of the person who has registered in the Special Needs Program, this authorization does not terminate and is not revoked unless a written notification of revocation and/or termination is received by EMA. Every effort is made to keep this information up-to-date and current, however, St. Clair County makes no representations or warranties of any kind, express or implied, about the completeness, accuracy, reliability, suitability or availability with respect to information for any purpose.
I expressly agree that St. Clair County EMA/911 will not be liable for any damages of any kind arising from the use of this form, including, but not limited to direct, indirect, incidental, punitive and consequential damages. Certain state laws do not allow limitations on implied warranties or the exclusion or limitation of certain damages. If these laws apply to me, some or all of the above disclaimers, exclusions, or limitations may not apply to me and I might have additional rights.

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Signed By:

Sign form and deliver to: St. Clair EMA
1610 Cogswell Ave Suite B10
Pell City, AL 35125

If you are the power of attorney for a special needs individual, please request an affidavit of non-revocation. Go to www.stclairco.com or call the EMA at 205-884-6800.

STATE OF ALABAMA
ST. CLAIR COUNTY

AFFIDAVIT OF NON-REVOCATION OF POWER OF ATTORNEY

Before me, the undersigned authority, a Notary Public in and for said County and State, personally appeared

who after first being duly sworn by me, deposes and says as follows:

1. My name is , I am over the age of twenty-one (21) years, and have personal knowledge of the facts stated herein.

2. On , (name of principal) appointed me as Attorney in Fact under a Power of Attorney, a true and correct copy of which is attached hereto as Exhibit "A".

3. I have on this day exercised the above referenced Power of Attorney by executing the Special Needs Information Participation Program form and authorization (the "Authorization") and other documents relating thereto.

4. At the time of the execution of the above mentioned Authorization and exercise of the Power of Attorney, I had no actual knowledge of the termination of the said Power of Attorney by revocation or of (name of principal's) death. I know (name of principal's) to be still living, and have never been notified since the execution of the Power of Attorney that he/she has revoked said power.

5. I am making this affidavit pursuant to Code of Alabama 1975, Section 26-1-2(a).

Witness my hand and seal this the ____ day of _____, 20___.

Affiant and Attorney in Fact

Sworn to and subscribed before me this the ____ day of _____, 20___.

Notary Public

My Commission Expires:

_____

And a copy of the Power of Attorney should be attached as Exhibit "A" as stated in paragraph 2 of the Affidavit.

Print Form