

ROLESVILLE POLICE DEPARTMENT

TELEPHONE REASSURANCE PROGRAM

Participant Application

Official use only Participant# _____

Name:			Date:		
Street:			Phone:		
City, State:		Zip:	Birth Date:		Age:
Email:				Sex:	Male Female
I live alone: Yes No		If No, Explain:			
Primary Physician:			Phone:		
Primary Hospital:					
Do you have a lifeline: Yes No		Which Hospital/Agency:			
Do you have a hidden key: Yes No		Location:			
Vehicle Make:			Model:		
License Plate #:			Year:		Color:
Emergency Contacts					
Name:			Name:		
Address:			Address:		
Primary Phone:		Secondary Phone:		Primary Phone:	
				Secondary Phone:	
Relationship:			Relationship:		
Do either of your emergency contacts have a key to your home?					
If yes, who?					

In requesting to become a program participant, I understand that a confidential file will be kept including this application and other notes/information regarding my participation. This record is confidential and will not be released without my consent. This program is voluntary and I may cancel at any time. There is no cost for any services that this program provides.

Signature: _____ Date: _____