



# WESTWOOD TOWNSHIP POLICE DEPARTMENT SPECIAL NEEDS REGISTRY APPLICATION

The Westwood Police Department Special Needs Registry is a voluntary service open to all citizens with disabilities who reside, attend school, or are employed within Westwood Borough. The registry was created to help police officers and other emergency personnel better assist individuals with special needs in the event of an emergency by providing those first responders with vital information regarding a registrant's disability, emergency contact information, physical description, and current photograph.

## Registrant Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_ Nickname (if any): \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Driver's License Number (if applicable): \_\_\_\_\_ Driver's License State: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Person Completing This Form (if different from above)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Relationship to Registrant: \_\_\_\_\_

## Vehicle Information (if applicable)

Does the registrant own or operate a motor vehicle?  Yes  No

License Plate #: \_\_\_\_\_ State: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ Color: \_\_\_\_\_

License Plate #: \_\_\_\_\_ State: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ Color: \_\_\_\_\_

Does the registrant own or operate a bicycle?  Yes  No

Make: \_\_\_\_\_ Model: \_\_\_\_\_ Speeds: \_\_\_\_\_ Color: \_\_\_\_\_

## Registrant Physical Identifiers

Date of Birth: \_\_\_\_\_ Gender:  M  F  Non-Binary Race: \_\_\_\_\_ Height (ft): \_\_\_\_\_ (inches): \_\_\_\_\_

Weight (in pounds): \_\_\_\_\_ Build (required): \_\_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Corrective Lenses:  Contact Lenses  Eye Glasses  Prescription Sunglasses

Scars/Piercings/Marks/Tattoos (location): \_\_\_\_\_

## Registrant Communication

Method of Communication:

Augmentative/Speech Assistance Device  Non-Verbal  Verbal  Sign Language  Written

What type of Augmentative/Speech Assistance Device does the registrant use? \_\_\_\_\_

What type of sign language does the registrant use? \_\_\_\_\_

What language(s) does the registrant speak or understand? \_\_\_\_\_

**Registrant School / Employment Information**

Does the registrant attend school or are they employed?  Yes  No

Name of School / Employer: \_\_\_\_\_

School / Employer Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

School / Employer Phone #: \_\_\_\_\_ Contact Name: \_\_\_\_\_

(Additional School / Employer)

Name of School / Employer: \_\_\_\_\_

School / Employer Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

School / Employer Phone #: \_\_\_\_\_ Contact Name: \_\_\_\_\_

**Registrant Special Need(s)**

Please indicate the registrants special need (select all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> Alzheimer's / Dementia                            | <input type="checkbox"/> Mental Illness                        |
| <input type="checkbox"/> Autism  | <input type="checkbox"/> Mobility Impairment / Wheelchair      |
| <input type="checkbox"/> Diabetes / Hyperglycemic (Type: _____ )           | <input type="checkbox"/> Mobility Impairment / Other: _____    |
| <input type="checkbox"/> Dialysis  | <input type="checkbox"/> Oxygen Dependent                      |
| <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Project Life Saver                    |
| <input type="checkbox"/> Electricity Dependent                             | <input type="checkbox"/> PTSD (Post-Traumatic Stress Disorder) |
| <input type="checkbox"/> Hard of Hearing / Deaf / Other Hearing Impairment | <input type="checkbox"/> Service Animal                        |
| <input type="checkbox"/> I/DD – Intellectual / Developmental Disability    | <input type="checkbox"/> Speech Impairment                     |
| <input type="checkbox"/> Life Alert  | <input type="checkbox"/> Vision Impairment / Blind             |
| <input checked="" type="checkbox"/> Other: _____                           |  |

Describe any of the registrant's life threatening medical concerns (e.g. food or medicine allergies, seizures, etc.): \_\_\_\_\_

Does the registrant use an Epi-pen?  Yes  No

If yes, where is it stored? \_\_\_\_\_

Any Triggers which affect the registrant (e.g. loud noises, bright lights, etc.):  Yes  No

If yes, please explain: \_\_\_\_\_

Any calming techniques / methods used for the registrant?  Yes  No

If yes, please explain: \_\_\_\_\_

Does the registrant frequent / gravitate to water, playgrounds, etc.?  Yes  No

If yes, provide location(s): \_\_\_\_\_

What products / equipment (e.g. pendent, wristband, mobile app, etc.) and with which vendor does the registrant have a Life Alert or a

Project Life Saver device: \_\_\_\_\_

Does the registrant have a service animal?  Yes  No

If yes, provide type/description, name, and what the service animal assists with: \_\_\_\_\_

\_\_\_\_\_

Does the registrant have a Social Worker / Case Worker assigned?  Yes  No  
If yes, Social / Case Worker Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Any other information that may be important? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Primary Emergency Contact Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Relationship to registrant: \_\_\_\_\_  
Is this person the legal guardian of the registrant?  Yes  No

**Secondary Emergency Contact Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Relationship to registrant: \_\_\_\_\_

**REGISTRANT PHOTOGRAPHS:** Please provide as many photographs of the registrant that you feel are necessary to properly identify the registrant. Photographs may be included with this application if it is being mailed or dropped off at police headquarters. If you are returning this application via e-mail, please include any photographs as attachments.  **PHOTOGRAPHS SUBMITTED**

**ACKNOWLEDGEMENT**

I acknowledge that the information being provided is truthful, current and valid; and that I am authorized to submit it on my own behalf or as the legal guardian with authority to submit it on behalf of the registrant. I further understand that by enrolling myself or the registrant in the Westwood Police Department's Special Needs Registry that the personal information provided in this application may be used by emergency personnel in the event of a personal emergency or other emergency situation involving the registrant. I also acknowledge that it will be my responsibility to keep the provided information up-to-date.

It is further understood that completion of this application and participation in the Westwood Police Department's Special Needs Registry is voluntary and cannot guarantee and is not intended to convey or warrant, either expressly or implied, any outcomes, promises, or benefits from participation in this program. Completion and submission of this application constitutes my acknowledgment and acceptance of these limitations and disclaimers.

I have read and understand the above disclaimer (required):  Yes  No

\_\_\_\_\_  
(Signature of Person Completing the Application)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name)

**Please return this completed application to (please remember to include photographs):**

**By mail or in person:**

**Westwood Police Department  
101 Washington Avenue, Westwood, NJ 07675**

**By e-mail:**

**policerecords@westwoodnj.gov**