DATE________________ ZONE _________ Lot # ________

EMERGENCY/DISASTER INFORMATION FORM

The Southbay Community Emergency Response Team consists of neighbors who have received training from Sarasota County emergency providers. The neighborhood is divided into six zones, each with a zone captain and co-captains. In order to help the team in an emergency (hurricane, tornado, flood, fire, terrorists activity, etc.) we are asking homeowners to provide certain information. The information you provide is strictly voluntary and is to be maintained by the zone captain and the Southbay office. If you feel that a certain question is to invasive, please skip over the question. Please return this completed form to the Southbay office. Thank you.

STREET ______________________________________HOUSE # ____________________

TELEPHONE CONTACT #______________________CELLPHONE # __________________

RESIDENTS NAMES____

ADULTS ____________ # CHILDREN ____________ # TYPE PET(S)________________

RESIDENCY? ______ YEAR ROUND _______PART TIME ________ MONTHS GONE______

EMAILADDRESS____

EMERGENCY CONTACT NAME _______________________PHONE # ________________

NEIGHBOR WITH ACCESS TO HOME? _______________________ PHONE # __________

LOCATION OF SHUTOFFS:

HAZARDOUS MATERIALS:	**LOCATION**
___PAINT /THINNER	________________________
___GASOLINE	________________________
___OTHER FLAMMABLES	________________________
___OXYGEN TANK	________________________
___AMMUNITION	________________________

SPECIAL NEEDS:

____OXYGEN

____WHEELCHAIR BOUND

____BEDRIDDEN

____MEDICAL

____OTHER (PLEASE SPECIFY)

____

UNDERGROUND GAS/PROPANE ____

ELECTRICAL ____

WATER____

Will you be willing to help CERT Team if needed after a disaster? _______YES ______NO

Please list any special skills that could be helpful to CERT Team________________________

____

____

____

MEDICALLY DEPENDENT RESIDENT INFO TO BE COMPLETED ON BACK OF THIS FORM (Optional)

Appendix A

SOUTHBAY MEDICALLY DEPENDENT RESIDENT FORM

The SOUTHBAY Community Emergency Response Team will assist residents who are medically dependent during a government-declared emergency if we are able to do so. Please fill out the form below and arrange to review it with the Community Manager and your Zone Captain.

COMPLETION OF THIS FORM IS OPTIONAL.
Providing the information below in no way obligates SOUTHBAY to provide any services.

Person Who Needs Assistance

Last Name	First Name
Street Address	Full or Part Time Resident (circle one) If Part time, months here:
Home Phone:	Cell Phone:
Who else lives at this address?	Relationship?
Have you registered with Sarasota County *Medical Needs Program?* (Circle One) YES NO	
SOUTHBAY CERT Zone:	SOUTHBAY Zone Captain:

Who Should We Contact In An Emergency Or Potential Evacuation?

Home Health Agency:	Phone:
Caregiver:	Phone:
Nearest Family Member (not at this address) Who Can Assist You:	Phone:

Reason You Need Assistance

Mobility	(Circle any that apply) Bedridden Wheelchair Walker Cane
Power Dependent	(Circle any that apply) O2 Concentrator CPAP Ventilator Other (explain): I have a source of emergency power (Generator): YES NO
Other	(Circle any that apply) Legally Blind Deaf Mute Other (explain):