Veazie Police Department

Application for the
Alzheimer and Eldercare Patient Listing Database

Patient Name ____ **Date of Birth**____________

Address ____ **Phone #**_________________

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Height	**Weight**	**Eye Color**	**Hair Color**

Distinguishing Characteristics (glasses, scars, tattoos, etc.)

Medical Conditions

Cautions

Care Provider	**Emergency Contact Person**
Name____	Name______________________________________
Address ____	Address_____________________________________
____	_____________________________________
Phone # ______________________________________	Phone #____________________________________
Physician's Name________________________________	Hospital Preferred___________________________

I certify that I am the primary care provider for this patient. I understand that this information is provided only to assist the Veazie Police Department in contacting either myself or the emergency contact person if the patient becomes disoriented. (This statement must be affirmed before a notary.)

___________________________	_____________	_______________________	________
Primary Care Provider	Date	Notary Public	Date

Send this completed form to: Veazie Police Department, Eldercare Application, 1084 Main Street, Veazie, Maine 04401. A recent photograph of the patient is helpful, but not mandatory.