City of Oakland
9-1-1 Registry Questionnaire

Introduction

The City of Oakland 9-1-1 Registry program allows people with disabilities and senior citizens to provide information about their health and medical needs to the City. This information is used for the purpose of providing effective and fast emergency services. The following questionnaire is designed to elicit information from individuals with disabilities and senior citizens who wish to participate in the 9-1-1 Registry program. This program is free and voluntary to eligible participants. Persons with disabilities and senior citizens living in the City of Oakland are eligible to participate in the 9-1-1 Registry program.

You should use this form to create a new profile or to update an existing profile. You **must** update your information at least once every five years whether or not your information has changed.

You can remove your information from the 9-1-1 Registry at any time by contacting the City of Oakland Fire Department at the telephone number or e-mail address below.

By completing this form, I understand that I grant permission to the Oakland Fire Department to disclose my information to emergency responders and other responding agencies, as needed. I understand that the information provided to the 9-1-1 Registry is to be used to provide specific information to medical professionals and response teams during an emergency. I understand the Oakland Fire Department may provide me with assistance within its capabilities but participation in the 9-1-1 Registry does not imply or guarantee that any assistance will be available.

Contact Information

If you have questions about the City of Oakland 9-1-1 Registry or need assistance filling out this form, please contact:

City of Oakland Fire Department Office of Emergency Services
1605 Martin Luther King, Jr. Way
Oakland, CA 94612
VOICE: 510-238-3938
TTY: 510-839-6451

City of Oakland
9-1-1 Registry Questionnaire

PLEASE CHECK ONE:

☐ New Profile

☐ Update Profile

DATE: _____

NAME: _____
Last Name First Name Middle Initial

DATE OF BIRTH: _____ / _____ / _____ GENDER: ☐ MALE
(MM) / (DD) / (YYYY) ☐ FEMALE

HOME ADDRESS: _____

CITY: _____ ZIP CODE: _____

MAILING ADDRESS (if different from above): _____

CITY: _____ ZIP CODE: _____

PHONE NUMBER: _____ CELL / MOBILE NUMBER: _____

WORK NUMBER: _____ TTD / TTY NUMBER: _____

E-MAIL ADDRESS: _____

HEIGHT: _____ WEIGHT: _____

DISTINGUISHING FEATURES TO HELP US IDENTIFY YOU: _____

_____

DO YOU HAVE A DISABILITY? ☐ YES ☐ NO

DISABILITY TYPE (CHECK ALL THAT APPLY):

☐ MOBILITY DISABILITY ☐ BLIND / VISUAL DISABILITY

☐ DEAF / HARD OF HEARING ☐ COGNITIVE DISABILITY

☐ MENTAL HEALTH DISABILITY ☐ OTHER: _____

PLEASE CHECK YOUR PRIMARY MOBILITY AID:

☐ MOTORIZED WHEELCHAIR ☐ MANUAL WHEELCHAIR

☐ MOTORIZED SCOOTER ☐ CANE / CRUTCHES / WALKER

☐ WHITE CANE ☐ OTHER: _____

☐ REMAIN IN BED ☐ I DO NOT USE A MOBILITY AID

PLEASE CHECK ALL OF THE FOLLOWING WHICH DESCRIBE YOUR NEEDS:

☐ AMERICAN SIGN LANGUAGE ☐ HEARING AID

☐ LARGE PRINT ☐ BRAILLE ONLY

☐ VENTILATOR DEPENDENT ☐ OXYGEN DEPENDENT

☐ PERSONAL CARE ATTENDANT REQUIRED TO MEET ACTIVITIES OF DAILY LIVING

☐ OTHER: _____

DO YOU USE MEDICAL EQUIPMENT THAT REQUIRES DAILY GAS OR ELECTRICITY AND IS ESSENTIAL FOR YOUR SURVIVAL? ☐ YES ☐ NO

IF YES, PLEASE LIST THESE ITEMS:

☐ VENITALOR ☐ MEDICATION / NUTRITION INFUSION EQUIPMENT

☐ IV PUMP ☐ AIR INFLATING MATTRESS OR SEAT CUSHION

☐ DIALYSIS TREATMENT ☐ HEATING OR COOLING EQUIPMENT

☐ HOYER LIFT ☐ OTHER: _____

DO YOU HAVE A SERVICE ANIMAL? ☐ YES ☐ NO

DO YOU HAVE AN EMOTIONAL SUPPORT ANIMAL? ☐ YES ☐ NO

DO YOU HAVE A PET? ☐ YES ☐ NO

PLEASE DESCRIBE THE TYPE AND COLOR OF EACH ANIMAL: _____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST ALL MEDICATIONS TO WHICH YOU ARE ALLERGIC:

_____

_____

_____

IF YOU HAVE ANY OTHER FUNCTIONAL OR DISABILITY-RELATED NEEDS THAT YOU WOULD LIKE TO MAKE KNOWN AT THIS TIME, PLEASE USE THE SPACE BELOW TO PROVIDE THIS INFORMATION:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

OTHER:

DOES YOUR HOME USE A REMOTE CONTROL DOOR OPENER? ☐ YES ☐ NO

IF YES, WHERE IS THE DOOR OPENER LOCATED?

☐ FRONT DOOR ☐ SIDE DOOR ☐ BACK DOOR

IS THE DOOR OPENER BATTERY OPERATED? ☐ YES ☐ NO

IS THE DOOR OPENER OPERATED BY ELECTRICITY? ☐ YES ☐ NO

DO YOU HAVE A STANDARD SMOKE DETECTOR? ☐ YES ☐ NO

WOULD YOU BENEFIT FROM A SMOKE DETECTOR FOR THE DEAF AND PERSONS WHO ARE HARD OF HEARING? ☐ YES ☐ NO

WOULD YOU BENEFIT FROM A LARGE BUTTON TELEPHONE WITH RAISED VOLUME CONTROL? ☐ YES ☐ NO

MEDICAL CARE CONTACT:

NAME OF PHYSICIAN: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

PHONE NUMBER: _____

OTHER HEALTH CARE PROVIDER: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

PHONE NUMBER: _____

EMERGENCY CONTACTS:

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: _____ CELL / MOBILE NUMBER: _____

WORK NUMBER: _____ TTD / TTY NUMBER: _____

RELATIONSHIP: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: _____ CELL / MOBILE NUMBER: _____

WORK NUMBER: _____ TTD / TTY NUMBER: _____

RELATIONSHIP: _____

PLEASE CIRCLE ONE:

I (DID) / (DID NOT) have assistance completing this form.

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_____ _____

APPLICANT SIGNATURE DATE

NAME OF PERSON PROVIDING ASSISTANCE: _____

AGENCY / RELATIONSHIP TO APPLICANT: _____

DATE: _____

PLEASE RETURN COMPLETED FORMS TO:

Oakland OES Attn: 911 Registry
1605 Martin Luther King, Jr. Way
Oakland, CA 94612

For alternative format versions or assistance with completing this form over the phone, please contact:

Oakland Fire Department Office of Emergency Services
1605 Martin Luther King, Jr. Way
Oakland, CA 94612
VOICE: 510-238-3938
TTY: 510-839-6451

Oakland Department of Human Services / OSCAR c/o Sarah Lin
150 Frank Ogawa Plaza, Suite #4340
Oakland, CA 94612
VOICE: 510-238-2382
TTY: 510-238-3254