



Department of Public Safety Communications

Alert Notification Form

Name of Residence/Business _____

Street Address _____

City _____ **Zip Code** _____ **Phone Number** _____

Please provide special requirements/needs/conditions below:

Examples: Oxygen, ventilators, or confinement to a wheelchair/bed; bariatric concerns or residential access issues such as gate codes that could cause a response delay.

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Patient Signature: _____

Date: _____

Please Return Form To: *Department of Public Safety Communications
PO Box 12430
Rock Hill SC 29731
Phone: 803-329-0911 Fax: 803-328-6225*

**York County 9-1-1 has the ability to document medical conditions or special needs of individuals in our Computer Automated Dispatch System. Having this information is beneficial to both you and the emergency responder; this includes fire, police, and medical. The information provided will be kept on file for one year. A new form will be mailed annually (January 1st) to verify the continued need for your information to be maintained.*