

OAKDALE POLICE DEPARTMENT

CITIZENS ASSISTANCE PROGRAM

Registration Form

Name of person to be checked on: _____

Address: _____ Phone(s): _____

Illnesses: _____ Medications: _____

Vehicle Information: (make, color, license number) _____

Closest Relative's Name: _____ Phone(s) _____

Closest Relative's Address: _____

Person to contact in emergency: _____ Phone(s) _____

Closest Key Holder: _____ Phone(s): _____

Doctor: _____ Phone(s): _____

Additional Information that will help in an emergency:

What is your relationship to the person being checked: _____

Your signature authorizing the Oakdale Police Department to make the visit:

Signature: _____ Date: _____