PLAINFIELD POLICE DEPARTMENT
14300 S. COIL PLUS DRIVE, PLAINFIELD, IL 60544
PHONE: 815-436-6544

PLAINFIELD FIRE PROTECTION DISTRICT
15025 N. DES PLAINES, PLAINFIELD, IL 60544
PHONE: 815-436-5335

SPECIAL NEEDS ALERT PROGRAM (SNAP) APPLICATION

NAME:			NICKNAME:	
HOME ADDRESS:				
HOME PHONE #:			DATE OF BIRTH:	
HT:	WT:	HAIR:	EYES:	GLASSES: Y / N
STATE ID FILE NUMBER (FOR PURPOSES TO OBTAIN PHOTOGRAPH FOR POLICE USE):				
CARE PROVIDER'S NAME:			PHONE NUMBER:	
CARE PROVIDER'S ADDRESS:				
MEDICAL CONDITION OR BEHAVIOR WHICH REQUIRES THE SPECIAL NEEDS AWARENESS:				
MEDICATIONS WHICH MAY BE APPLICABLE TO THE SPECIAL NEEDS AWARENESS:				
BEHAVIOR WHEN NOT ON MEDICATION:				
DOES THIS PERSON EXHIBIT ANY HYPER OR HYPO SENSITIVE REACTIONS TO ANY STIMULI:				
PERSONS HABITS/INTERESTS/PLACES THEY MAY BE LIKELY TO GO:				
ANY SPECIAL CONSIDERATIONS POLICE/FIRE PERSONNEL SHOULD TAKE WHEN APPROACHING THIS PERSON:				

I understand the information given above is intended to offer guidance and provide assistance to responders in assisting those people with special needs or disabilities in the performance of their duties. Presenting this information will not entitle to or result in any form of preferential treatment. This information will be kept on file until June 1 of each year, after which the information will be removed from the database. It is the responsibility of the applicant to provide a new application to be included in the database. Previous years entries will not be included and no notice will be given to the applicants prior to the removal of information. The information entered into the Special Needs Alert Program (SNAP) database shall remain confidential. This information will be relayed to responding public safety personnel via any means available. The undersigned hereby verifies the above person has a physical or mental impairment, or has or is at increased risk for a chronic physical developmental, behavioral, or emotional condition and who also requires health and related services of a type or amount beyond that required by individuals generally. The undersigned is the above named individual, a family member, friend, caregiver, or medical personnel familiar with the individual. By signing, I certify I have read and understand this form in its entirety and hereby give permission to the Plainfield Police Department to enter this information into the Special Needs Alert Program (SNAP).

YOU MAY BE CONTACTED BY THE PLAINFIELD FIRE PROTECTION DISTRICT IF ADDITIONAL MEDICAL INFORMATION IS REQUIRED.

Print Name: _____ Relationship: _____

Signed: Date:

PLEASE MAIL THIS FORM TO ONE OF THE ADDRESSES LISTED ABOVE FOR PROCESSING.