SHERIFF'S OFFICE, COUNTY OF SUFFOLK, N.Y.
ACCREDITED LAW ENFORCEMENT AGENCY
PROJECT LIFESAVER BUREAU
100 CENTER DRIVE
RIVERHEAD, N.Y. 11901
(631) 852-3003

ERROL D. TOULON, JR., Ed.D.
SHERIFF

PROJECT LIFESAVER ENROLLMENT APPLICATION (ADULT)

Client Name: _____

Nickname(s): _____

Address: _____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Length of time residing at the above address: _____

Former address(s) of client: _____

_____

CLIENT DESCRIPTION

Date of Birth: _____ Current Age: _____ Sex: ☐ Male ☐ Female

Height: _____ ft. _____ in. Weight: _____ Build: _____

Hair Color: _____ Hair Style: _____ Eye Color: _____

Race: _____ Complexion: _____

Facial Hair: _____

Distinguishing scars, marks, tattoos (describe): _____

_____

_____

If the client does not understand English, indicate what language is understood: _____

Glasses: ☐ Yes ☐ No Hearing Aids: ☐ Yes ☐ No Mobility Aids: ☐ Cane ☐ Walker

Does client go out alone?: ☐ Yes ☐ No Explain if "Yes": _____

_____

CLIENT HEALTH

Diagnosis: _____ Diagnosed when: _____

Additional known medical issues: _____

_____

Known psychological issues: _____ Zip Code: _____

_____ Cell Phone: _____

Known physical handicaps: _____

_____

Medications (name, dosage, and frequency: _____

_____

Attending Physician: _____ Phone No.: _____

WANDERING / ELOPEMENT HISTORY

Prior history of wandering: ☐ Yes ☐ No If "Yes," explain including dates, locations and outcomes: _____

_____

_____

CLIENT HABITS / PERSONALITY

Uses tobacco products: ☐ Yes ☐ No Carries matches: ☐ Yes ☐ No Carries lighter: ☐ Yes ☐ No

Uses alcohol: ☐ Yes ☐ No If "Yes", type and frequency: _____

Carries cash: ☐ Yes ☐ No If "Yes", amount and where carried: _____

Interests / hobbies: _____

☐ Outgoing, or ☐ Quiet Talks to strangers: ☐ Yes ☐ No Danger to self or others ☐ Yes ☐ No

Client fears (dogs, cats, people, noises, darkness, etc.): _____

_____

Client actions when hurt or frightened (cry, shout, hide, etc.): _____

_____

Client has access to a vehicle: ☐ Yes ☐ No If "Yes", plate number of vehicle(s): _____

INDIVIDUALS CLIENT MAY CONTACT IF LOST / WANDERING / ELOPED

Name: _____ Relationship to Client: _____

Address: _____

Name: _____ Relationship to Client: _____

Address: _____

Name: _____ Relationship to Client: _____

Address: _____

CAREGIVER(S)

Name: _____ Relationship to Client: _____

Address: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Employer Name: _____

Employer Address: _____

Work Phone: _____ E-mail: _____

Name: _____ Relationship to Client: _____

Address: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Employer Name: _____

Employer Address: _____

Work Phone: _____ E-mail: _____

LONG TERM / MANAGED CARE / NURSING HOME CLIENTS

Facility / Organization Name: _____

Address: _____

Contact Person: _____ Phone: _____ Fax: _____

POWER OF ATTORNEY

Name: _____ Relationship to Client: _____

Address: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

LIABILITY INFORMATION/RELEASE

Please read this section carefully and sign prior to submitting the application

I, (caregiver name) _____, acknowledge that the information I have provided in this application is true and accurate. I understand that acceptance into the Suffolk County Sheriff's Office Project Lifesaver Program **does not replace the need for constant supervised care of the client**.

(A) I, (caregiver name) _____ attest that (client name) _____ is personally supervised by me and/or by another **responsible adult, 24 hours a day, 7 days a week**.

(B) I, (caregiver name) _____ attest that (client name) _____ **is not left unsupervised at any time**.

If both statements (A) and (B) above are NOT TRUE, the potential client is ineligible for enrollment in the Project Lifesaver Program. If any portion of the caregiver(s) responses are inaccurate, the client will no longer be eligible for participation in the Project Lifesaver Program.

I understand that while Project Lifesaver utilizes a global tracking device that aids in locating individuals who wear the transmitter, there may be times when an individual cannot be located due to device malfunction or other unforeseen circumstances. I agree to assume any/all responsibility associated with participation in the Suffolk County Sheriff's Office Project Lifesaver Program.

I understand that the information I have provided in this application will be shared within the Suffolk County Sheriff's Office and with other search and rescue agencies/organizations. I understand that none of the information I have provided, or provide in the future, will be considered confidential or protected.

I also understand that Project Lifesaver is a program sponsored by the Suffolk County Sheriff's Office and works in collaboration with other area agencies. Should the client be accepted in the Project Lifesaver Program, he/she agrees to release and hold the County of Suffolk, the Sheriff of Suffolk County and each agency and their respective personnel harmless from any and all claims of liability and/or damage and waive any and all rights to seek recourse for any losses or injury that may occur as a result of their participation in the Suffolk County Sheriffs Office Project Lifesaver Program.

I have read the Project Lifesaver "Fact Sheet" and agree to its terms and conditions. I represent the client and proclaim that I have **full power and authority as the duly authorized representative of the applicant** to register and act on his/her behalf.

Print Caregiver Name: _____

Caregiver Signature: _____