

**Siskiyou County Public Health**  
**Voluntary Registration Request for Access and Functional Needs**  
**Individuals Emergency Response Form**

## **This Is Not a Rescue Plan!**

By signing up for the Access and Functional Needs (AFN) registry, it places your name and information on a contact list at the Siskiyou County Public Health Department. However, by being on this list participants **MUST** understand the following disclaimers:

- Being added to the list **SHOULD NOT** be your plan for evacuation. You should always have your own plan to evacuate with neighbors, friends or family to leave if an evacuation is ordered.
- Being on this list **DOES NOT** guarantee first responders **WILL** make contact with you during any type of disaster or evacuation. **DO NOT** wait for them to come get you or assist you, but rather revert to your “plan A” to leave.
- The AFN list is only intended to inform first responders of your location and that you may need assistance should you be in the evacuation area. It is not a dispatch. If available, first responders may attempt to contact you and/or locate you **If the Resources Are Available** to do so. Again, the information we share with first responders is to alert them of you and your location, **NOT** to dispatch resources. Understand that during a disaster with evacuations, the resources will be stretched thin and limited therefore they **MAY NOT** be able to assist you.

Complete the form on the next pages and return to Siskiyou County Public Health, Emergency Preparedness Division as directed on the last page of the form.



**Primary Physician Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Psychiatrist/Therapist Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Home Health Care Provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency Contact Person:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Do you have a reliable method of Transportation?**                      Yes                      No

If no, check the appropriate transportation type needed:

Standard Vehicle (Bus or Car)                      Wheelchair Equipped                      Ambulance

**Will a caregiver or service animal accompany you to a shelter, if needed?**                      Yes                      No

Relationship of caregiver: \_\_\_\_\_

Do you have a household pet(s)?      Yes                      How many? \_\_\_\_\_

**Medical Condition/Level of Independence:**

**Amount of Assistance Needed (Check One)**

- Bedridden
- Maximum Assist – unable to feed self, walk alone.
- Moderate Assist – need help to do daily activities.
- Minimal Assist – only require a small amount of help.
- Independent

**Type of Heating in Home (Check One)**

- Wood
- Gas (Propane, Diesel)
- Electric

**Water Source in Home (Check One)**

- City or Community System
- Well
- Natural Spring Water

**Please Check Before Submitting:**

I give consent to the Siskiyou County Public Health Department to share information on this form with Emergency Services **only during a disaster that may affect the address provided.**

**Return completed form to:** Siskiyou County Public Health Department

Attn: Emergency Preparedness  
810 South Main Street  
Yreka, CA 96097  
530-841-2134  
Fax: 530-841-4092