Florida Special Needs Registry
Registration Information - Sumter County

Instructions: Complete this form and fax or mail it to Sumter County to register an individual for the Florida Special Needs Registry. This form is not required if you have already registered on line. Required fields are indicated with an asterisk (*).

Mail: Sumter County Special Needs Registry
Post Office Box 98
Attn: Special Needs Registry
Bushnell, FL 33513

Fax: (352) 689-4676

PERSONAL INFORMATION ABOUT THE REGISTRANT	
*First Name	
*Last Name	
*Birth Date	
*Gender (select only one)	☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Prefer Not To Provide
*Height	Feet: Inches:
*Weight (pounds)	
*Primary Language	
Are you completing this form on behalf of the registrant? If so, please indicate your relationship to the registrant (select only one)	☐ Family Member ☐ Caregiver ☐ Neighbor ☐ Friend ☐ Home Health Care Provider ☐ County Emergency Management Staff ☐ County Health Department Staff ☐ DOH State Staff

ADDRESS FOR THE REGISTRANT (physical address is required)	
*Physical Address (cannot be a PO Box)	
Apt #, Unit #, Bldg #, Suite #, etc.	
*Physical City	
*Physical State	FL
*Physical Zip Code	

PHONE NUMBERS FOR THE REGISTRANT (a primary and at least one other phone number is required)

*Phone Number	Extension	*Phone Type (select only one)	Primary	TTY/TDD Capable
( ) -		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No
( ) -		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No
( ) -		☐ Home ☐ Work ☐ Cell	☐ Yes ☐ No	☐ Yes ☐ No

PRIMARY EMERGENCY CONTACT FOR THE REGISTRANT (required)	
*Primary Emergency Contact Name	
*Contact Primary Phone Number	( ) - Extension:

REGISTRANT'S EQUIPMENT

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REGISTRANT'S EQUIPMENT

Please indicate the medically necessary equipment that is electric dependent for this registrant: (select all that apply)	☐ Apnea Monitor ☐ Cardiac Monitor ☐ CPAP / BiPAP ☐ Dialysis Catheter ☐ Feeding Pump ☐ Medication that requires refrigeration ☐ Nebulizer ☐ Oxygen Concentrator ☐ Suction Pump ☐ Ventilator ☐ Wound Vac Other:

TRANSPORTATION & MOBILITY

Registrant has the following transportation needs: (select all that apply)	☐ Must be transported in a wheelchair accessible vehicle ☐ Needs continuous oxygen during transport ☐ Just needs transportation to a shelter
Registrant has the following mobility issues: (select all that apply)	☐ Is confined to a bed ☐ Is paralyzed (complete or partial) ☐ Uses a Walker ☐ Uses a Wheelchair ☐ Uses a Motorized Wheelchair / Scooter

MEDICAL & OTHER

Memory: (select all that apply)	☐ Alzheimer and related dementias
Dialysis Frequency: (select only one)	☐ 1 time a week ☐ 2 times a week ☐ 3 times a week ☐ 4 times a week ☐ 5 times a week ☐ 6 times a week ☐ 7 times a week (daily)
Oxygen Type: (select only one)	☐ Gaseous ☐ Liquid
Oxygen Liter Flow / Amount: (select only one)	☐ 1.0 ☐ 1.5 ☐ 2.0 ☐ 2.5 ☐ 3.0 ☐ 3.5 ☐ 4.0 ☐ 4.5 ☐ 5.0 ☐ 5.5 ☐ 6.0 ☐ 6.5 ☐ 7.0
Oxygen Mode of Administration: (select only one)	☐ Mask ☐ Nasal Cannula ☐ Trach Collar
Other: (select all that apply)	☐ Vision Impaired ☐ Deaf ☐ Incontinent Other:

OTHER NOTES ABOUT THE REGISTRANT