



W I S C O N S I N

CITY OF ELKHORN
9 SOUTH BROAD STREET
P.O. BOX 920
ELKHORN, WISCONSIN 53121

CITY 262-723-2219 LIGHT & WATER 262-723-2910
PUBLIC WORKS 262-723-2223 FAX 262-741-5131

Medical Alert Response Application

Name: _____ Date: _____

Address: _____

Phone: _____

Medical Equipment Used: _____

Do you have battery back-up for this Equipment? Yes _____ No _____

If yes, how long are you able to rely on the battery? _____

Do you rely on the Equipment 24 hours per day? Yes _____ No _____

If not, during what hours do you use the Equipment? _____

Are you or someone who lives with you able to answer the telephone during the hours specified above? Yes _____ No _____

Hours that you DO NOT wish to be contacted: _____

Is there another person we can contact if you do not answer your phone?

Name: _____ Phone: _____

If we cannot reach either of you by phone, do you want an ambulance dispatched to your location to check on you? (Any charge would be billed to your insurance company or yourself)

Yes _____ No _____

Please provide any further information that will help us to make contact with you in the event of an extended power outage: _____

Please note: A certified Physicians letter needs to be included with this form to be accepted.