PROJECT LIFESAVER
of
PIERCE & ST. CROIX
Program Application

Pierce Phone: 715-273-3531 St. Croix Phone: 715-381-4320

Applicant's Name: (Name of Individual for whom this application is being made)

FAMILY/CAREGIVER INFORMATION				
NAME:			**RELATIONSHIP TO APPLICANT:**	
Are you the Parent of, or Guardian of or do you have durable power of attorney for health care that has been activated for the Individual you are seeking to enroll in Project Lifesaver? YES / NO				
If not, please provide the name, address and phone number of who is, and their relationship to the Alzheimer's Individual, Autistic Person or person with other related disease.				
HOME ADDRESS:		**HOME PHONE #:**		**CELL PHONE #:**
FAX #:	**EMAIL ADDRESS:**		**EMPLOYER:**	
EMPLOYER ADDRESS:	**WORK PHONE#:**		**WORK EMAIL ADDRESS:**	

ADDITIONAL EMERGENCY CONTACT INFORAMTION				
NAME:			**RELATIONSHIP TO APPLICANT:**	
HOME ADDRESS:		**HOME PHONE #:**		**CELL PHONE #:**
FAX #:	**EMAIL ADDRESS:**		**EMPLOYER:**	
EMPLOYER ADDRESS:	**WORK PHONE#:**		**WORK EMAIL ADDRESS:**	

APPLICANT INFORMATION: (Individual who has Alzheimer's disease, Autism, or related disease)					
FULL LEGAL NAME:				**NICKNAME:**	
What is Applicant's specific diagnosis?					
When was the Applicant diagnosed?					
D.O.B.	**CURRENT AGE:**	**HEIGHT:**	**WEIGHT:**	**EYE COLOR:**	**HAIR COLOR**
Describe any other distinguishing physical characteristics:					
How long has this individual been living at this address?					

MEDICAL INFORMATION	
Is there any prior history of becoming lost or wandering from Home? If yes, please describe the event (s) in detail with dates. (attach additional paper if needed):	
Please list the name, address and phone number of the physician who diagnosed the Applicant:	*Describe any other health related problems:*

Please have the applicant's physician sign below verifying that the applicant is or may be at risk for wandering as indicated by specific diagnosis on front page.

Physician Name (printed) ______________________ **Date** ______________________

Physician Signature ______________________

Please fax or mail this application form to the Sheriff's Office of the County that you live in. After receiving this application, we will be in contact with you to set up an appointment.

St. Croix County Sheriff's
Inv. Shawn Demulling
1101 Carmichael Road
Hudson, WI 54016
715.381.4320 (phone)
715.386.4606 (fax)

Pierce County Sheriff's Office
Sheriff Nancy Hove
432 West Main Street
P.O. Box 9
Ellsworth, WI 54011
715.273.6816 (phone)
715.273.3409 (fax)

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Liability Release Information:

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

I ACKNOWLEDGE that the information I have provided in this application is true, accurate and complete to the best of my knowledge.

I UNDERSTAND that should the Applicant be accepted into Project Lifesaver that it does not replace the need for others to continue to provide constant supervised care of the Applicant.

I AGREE to assume all responsibilities associated with program participation and ongoing bracelet device maintenance.

I UNDERSTAND that while Project Lifesaver utilizes a global tracking device that aids in locating individuals who wear a bracelet device, there may be times and circumstances when an individual cannot be located due to device malfunction or other reasons.

I UNDERSTAND that all information I have provided in this application will be shared between the Pierce-St. Croix County Sheriff's Offices, and other appropriate agencies, as well as the police department in the town where the Applicant resides, and I understand that none of the information I have provided or may provide in the future can be considered confidential or protected.

I UNDERSTAND that Project Lifesaver is a program sponsored by the Pierce-St. Croix County Sheriff's Office that will work in collaboration with other area agencies; **AND SHOULD THE APPLICANT BE ACCEPTED INTO THE PROJECT LIFESAVER PROGRAM, HE/SHE AGREES TO RELEASE AND HOLD EACH AGENCY AND ALL THEIR RESPECTIVE PERSONNEL, DIRECTORS AND VOLUNTEERS HARMLESS FROM ANY AND ALL CLAIMS OR 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 PARTICIPATION IN THE PRJECT LEIFESAVER PROGRAM**.

I HAVE READ THE PROJECT LIFESAVER PROGRAM STANDARD OPERATING PROCEDURE AND AGREE TO THOSE TERMS. FURTHERMORE, I hereby represent and warrant that I have full power and authority as the duly authorized representative of the participant named above, to register and act on his/her behalf.

____
Name

____
Signature Date