**Register Special Medical Needs**

**Complete and Return this Form to the CCT Management Office**

**This form will be kept at the Front Desk in the event of an emergency.**

**Needs - Accommodation\* List**

|  |  |  |
| --- | --- | --- |
| **Name** | **Unit #** | **Needs** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**\*Special Accommodations (i.e. need assistance in an emergency,**

 **oxygen, wheelchair, etc.)**

**Emergency List – Nearest Relative**

|  |  |  |
| --- | --- | --- |
| **Name** | **Unit #** | **Emergency Number(s)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Remember: A wheelchair is available from the Front Desk to all residents.**