



CARE Program

Okaloosa County Sheriff's Office



Subject Information

Legal Full Name: _____ Telephone # to Call: _____

Date of Birth: _____ Sex: _____ Race: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Days of the Week to Call: _____ Weekends: _____

Number of Times a Day to Call: _____ Call Time: _____

Call Time: _____ Call Time: _____ 4 Digit PIN #: _____

Primary Care Physicians Name: _____

Disclaimer

If you are enrolled in the *CARE Program* and cannot be reached by the information provided a Deputy Sheriff will be sent to do a welfare check. If the individual enrolled in the *CARE Program* is okay, then the following steps will occur: the first and second time a warning letter and/or phone call will be sent to the individual and/or caretaker; the third time the person will be removed from the *CARE Program* for one year.

The information of the person on this form will be entered into the Okaloosa County Sheriff's Office "*CARE Program*" within the next **15** days.

Please note: Should there be any changes, it is the responsibility of the legal guardian or representative to notify the Sheriff's Office so that the program will contain the most up-to-date information.

Emergency Contact Information

1. Name: _____ Relationship: _____ Key Holder _____

Address: _____ E-mail Address: _____

Home #: _____ Cell #: _____ Work/Daytime #: _____

2. Name: _____ Relationship: _____ Key Holder _____

Address: _____ E-mail Address: _____

Home #: _____ Cell #: _____ Work/Daytime #: _____

3. Name: _____ Relationship: _____ Key Holder _____

Address: _____

Home #: _____ Cell #: _____ Work/Daytime #: _____

4. Name: _____ Relationship: _____ Key Holder _____

Address: _____

Home #: _____ Cell #: _____ Work/Daytime #: _____

5. Name: _____ Relationship: _____ Key Holder _____

Address: _____

Home #: _____ Cell #: _____ Work/Daytime #: _____

My signature below constitutes an affirmation under oath that I am the person named above or I am legally responsible for the named person above for whom I have provided information and that I consent to have this information shared among law enforcement personnel for enrollment in the "CARE" program.

Signature/Date

Witness