**SPECIAL NEEDS FORM**

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**DATE**:

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**NAME**:

FIRST MIDDLE LAST

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**ADDRESS**:

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**BUILDING/UNIT/APT#/LOT#**

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**CITY**:

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**TELEPHONE**:

**LOCATION IN RESIDENCE**: (i.e.,2nd bedroom on right)

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**MEDICAL CONDITION**: (i.e., Please no abbreviations)

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**LOCATION OF EQUIPMENT**: (Oxygen tanks)

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**MISC**: (i.e., House key location)

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**SUBMITTED BY**: **TITLE**:

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**AGENCY/COMPANY**:

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**TELEPHONE**: **FAX**:

\*\*SPECIAL NOTE\*\*

Please complete all fields; an incomplete form may delay processing of the information. This record will be purged ninety (90) days from entry date. A new form must be resubmitted to modify or delete current record. Please fax or email notification of any changes if less than ninety (90) days.

**ATTN**: **CAD SPECIALIST** **FAX**: (843) 915-6100 **EMAIL:** [HC911CAD@horrycountysc.gov](mailto:HC911CAD@horrycountysc.gov)