Dear Member,

Even with the best intentions and wise precautions, unexpected things can happen to us. The following information is ONLY a suggestion of what should be kept available, where it should be kept to be useful and who should know about it for your benefit. If your circumstances are different, then allowances should be made - but the concepts presented are important and we hope you will respond with your own plan. .

The first pages are for emergency situations that arise and may be used by you, someone who lives with you, a visiting nurse, therapist or health care provider, or anyone who happens to be present when problems may occur.

The second section deals with your medical situation or health status. This includes any necessary information to help emergency or medical personnel give you the care that you may require. It is a useful reminder for you to consult and it could prove invaluable if you become disabled for any reason. Some people keep separate copies of this information in the medicine cabinet and/or in a container in their refrigerator.

The last section contains information which may be needed to provide for your medical, emotional, fiscal or long-term care. This information should NOT be left where it may be found. It should be given to a trusted person only.

Some of the information listed should NOT be kept lying around unsecured and we suggest that you take any and all necessary precautions to protect your privacy while providing yourself with meaningful help in time of need. The pages with confidential information listed are marked with a row of asterisks along the side. These should be given to a trusted, honest, close and responsible relative, friend or neighbor. No one else should have access to that information

We hope you use the suggested format or one of your own choosing, but we hope you will see this information as useful.

Board of Directors,

Los Angeles Retired Fire and Police Association

EMERGENCY ASSISTANCE

Paramedic or Emergency Ambulance service

Telephone Number:_____

(Note: if your area has 911 service, please use.)

Fire Department Emergency service

Telephone Number:_____

(Note: if your area has 911 service, please use.)

Police Department Emergency service

Telephone Number:_____

(Note: if your area has 911 service, please use.)

Family Physician or Health Maintenance Organization

Name: _____

Telephone Number:_____

Dentist

Name: _____

Telephone Number:_____

24 Hour Pharmacy

Telephone Number:_____

Attorney

Name:_____

Address:_____

City:_____State:_____Zip Code: _____

Telephone Number:_____

Accountant

Name:_____

Address:_____

City:_____State:_____Zip Code: _____

Telephone Number:_____

Insurance Agent/Agency

Name:_____

Address:_____

City:_____State:_____Zip Code: _____

Telephone Number:_____

PERSONAL DATA

The following information should be carried with you or be available at all times.

Name:_____

Address:_____

City:_____State:_____Zip Code: _____

Telephone Number:_____Birth date: _____

Person to contact in case of emergency

Name:_____

Address:_____

City:_____State:_____Zip Code: _____

Telephone Number: _____

MEDICAL AND HEALTH CARE INFORMATION

Medicare Number: _____

Medical/ State Ins. Number: _____

Name of primary insurance provider or Health Maintenance Organization: _____

_____

Name of secondary insurance provider: _____

_____

Policy Number(s), Primary: _____

Policy Number(s), Secondary: _____

Telephone Number (primary): _____

Telephone Number (secondary):_____

MEDICAL INFORMATION

I have been or am being treated for the following disabilities or conditions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

I have the following allergies:

1. _____
2. _____
3. _____
4. _____

I am allergic to the following medications:

1. _____
2. _____

My Blood Type is:_____

My Cholesterol Level is:_____

Date of last test: _____

My Blood Sugar Level is: _____

Date of last test: _____

Conditions that require scheduled or regular treatments such as kidney dialysis, physical therapy, chemotherapy, etc.

Condition:_____

Treatment schedule time: _____

Location of treatment:_____

Condition:_____

Treatment schedule time: _____

Location of treatment:_____

DIETARY RESTRICTIONS

I am on the following type of diet: _____

_____

I take the following nutritional supplements: _____

_____

MEDICATIONS

I am taking the following:

Medication name: _____

Prescribed by Doctor: _____

Purpose:_____

Pharmacy where last filled:_____

Instructions/dosages/times to take: _____

_____

Possible side effects: _____

Medication name: _____

Prescribed by Doctor: _____

Purpose: _____

Pharmacy where last filled: _____

Instructions/dosages/times to take: _____

_____

Possible side effects: _____

Medication name: _____

Prescribed by Doctor: _____

Purpose: _____

Pharmacy where last filled: _____

Instructions/dosages/times to take: _____

_____

Possible side effects: _____

Medication name: _____

Prescribed by Doctor: _____

Purpose: _____

Pharmacy where last filled: _____

Instructions/dosages/times to take: _____

_____

Possible side effects: _____

Medication name: _____

Prescribed by Doctor: _____

Purpose: _____

Pharmacy where last filled: _____

Instructions/dosages/times to take: _____

_____

Possible side effects: _____

Medication name: _____

Prescribed by Doctor: _____

Purpose: _____

Pharmacy where last filled: _____

Instructions/dosages/times to take: _____

_____

Possible side effects: _____

Medication name: _____

Prescribed by Doctor: _____

Purpose: _____

Pharmacy where last filled: _____

Instructions/dosages/times to take: _____

_____

Possible side effects: _____

Medication name: _____

Prescribed by Doctor: _____

Purpose: _____

Pharmacy where last filled: _____

Instructions/dosages/times to take: _____

_____

Possible side effects: _____

Medication name: _____

Prescribed by Doctor: _____

Purpose: _____

Pharmacy where last filled: _____

Instructions/dosages/times to take: _____

_____

Possible side effects: _____

FAMILY AND FRIENDS

In case of emergency, please contact:

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

_____

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

The following information should only be shared with a trusted person that I/we live with, a trusted and reliable relative, or lastly a trusted, honest and reliable neighbor.

IMPORTANT DOCUMENTS

Name: _____

Social Security Number: _____

My valuable papers are stored in these locations (address plus where to look.)

A. My residence address: _____

B. Safe-deposit box: _____

C. Other location: _____

ITEM	LOCATION		
	A	B	C
My will (original)	____	____	____
My will (copies)	____	____	____
Power of Atty. for Health Care	____	____	____
Power of Atty. for business or other actions	____	____	____
Spouse's will (original)	____	____	____
Spouse's will (copies)	____	____	____
Safe and Combination _____	____	____	____

ITEM	LOCATION		
	A	B	C
Trust agreements			
Life Insurance Policy			
Health Insurance Policy			
Homeowners Policy			
Car Insurance Policy			
Worker's Comp. Awards			
List of Checking/Savings Accounts			
List of Credit Cards			
Brokerage Account Records			
Retirements papers			
Deferred Compensation or IRA papers			
Titles and Deeds			
Promissory notes or mortgages			
List of stored or loaned items			
Automobile ownership papers			
Birth Certificate			
Military Discharge papers			
Marriage Certificate(s)			
Children's Birth Certificates			
Divorce/Separation Records			
Lease or Rental Agreements			
Tax Returns			
Other _____			
Other _____			
Other _____			