Town of Fishkill Police

Cinch - An Emergency Contact Program

The information you provide will be used to assist emergency medical personnel in the event that you are unable to provide it. Your designated contact person will be notified of the emergency and informed if you have been taken to a medical facility.

THIS CONFIDENTIAL INFORMATION WILL ONLY BE RELEASED TO THOSE RENDERING MEDICAL ASSISTANCE

Please complete the form and mail to:

Town of Fishkill Police Dept.
807 Route 52
Fishkill, NY 12524

Last Name: _____ First Name: _____

Address:

_____

_____

_____

Home Phone: _____ Work Phone: _____

Date of Birth: _____

Primary Medical Condition: _____

Medications:_____

_____

Physician Name: _____ Physician Phone: _____

Hospital Preference: _____

Notes: _____

_____

Emergency Contact #1: _____ Phone #1:_____

Emergency Contact #2: _____ Phone #2:_____

Emergency Contact #3: _____ Phone #3:_____