REGENCY
at Monroe

2017/2018 SNOW SEASON

MEDICAL PRIORITY SNOW REMOVAL REQUEST FORM

Resident's Name: _____

Address: _____ Phone #: _____

Please check your criteria:

1. Chemotherapy/Radiation _____
2. Dialysis: _____
3. Hospice _____
4. In Home – Visiting Nursing Service _____

Place the time you have to leave your home for treatment next to the appropriate day. Be sure to complete your return home time so that we can make an effort to have your driveway clear upon your arrival home.

When completing this form, please add time for your commute in during bad weather.

Day	Leave Home	Appointment Time	Return Home
Sunday			
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			

Date Treatment is over: _____

Doctors Signature: _____ Phone #: _____

Be sure to have an ample supply of medications before a pending storm.

Call 911 if you require immediate emergency assistance.

Hospital personnel requesting priority must provide proof of employment, hospital badge and weekly/monthly schedule in order to be considered for **possible** early courtesy clearing.

Dated: November 8, 2017