



## MEDICAL ASSISTANCE FORM

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**To adequately provide assistance to those who require special medical attention or are in need of transportation off the island in the event of a natural disaster, please provide the following information:**

\_\_\_\_\_  
 Last Name First Name(s)

\_\_\_\_\_  
 Shipyard Address Phone Number

\_\_\_\_\_  
 Email Address Phone Number

**Please answer the following questions to the best of your ability and if anything changes, let us know.**

Do you require a wheelchair or any other equipment? \_\_\_\_\_

Are you currently under the care of a physician? \_\_\_\_\_

Physician's Name & Phone Number : \_\_\_\_\_

Do you require oxygen or special equipment? \_\_\_\_\_

If "yes" please explain : \_\_\_\_\_

\_\_\_\_\_

Contact person or next of kin : \_\_\_\_\_

Phone Number : \_\_\_\_\_

Email : \_\_\_\_\_

**The above information is required to determine the type of assistance you may require and the best means of providing you with the medical attention you need and deserve.**

Return the form to: Shipyard POA Welcome Center

10 Shipyard Drive

Hilton Head, SC 29928