

# FIRE DEPARTMENT CITY OF ENGLEWOOD

---



GOOD MORNING ENGLEWOOD IS A PROGRAM FOR ANY SENIOR CITIZEN, OR RESIDENT HAVING SPECIAL NEEDS, WHO LIVES ALONE WITH NO ONE TO LOOK IN ON THEM ON A DAILY BASIS. THE PROFESSIONAL FIRE DEPARTMENT OF ENGLEWOOD OFFERS THIS SERVICE TO ALL CITIZENS OF OUR COMMUNITY WHO MEET THE CRITERIA.

EVERY MORNING BETWEEN 8:30-9:30 A. M. A MEMBER OF THE FIRE DEPARTMENT WILL CALL PARTICIPANTS OF THE PROGRAM TO CHECK THAT EVERYTHING IS ALL RIGHT. IF THERE IS NO ANSWER, A SECOND CALL WILL BE MADE A FEW MINUTES LATER. IF NO ONE ANSWERS THE SECOND CALL, A FIRE DEPARTMENT UNIT WILL BE DISPATCHED TO THE ADDRESS TO MAKE SURE ALL IS WELL.

BEFORE STARTING THE PROGRAM A FIRE DEPARTMENT REPRESENTATIVE INTERVIEWS THE APPLICANT TO OBTAIN MEDICAL DATA AND IMPORTANT INFORMATION WHICH MAYBE VALUABLE IN AN EMERGENCY.

IF YOU FEEL THAT THIS PROGRAM WOULD BE OF HELP TO YOU, AND YOU MEET THE ABOVE REQUIREMENTS, FEEL FREE TO CALL FIRE HEADQUARTERS BETWEEN 8:00 A.M. AND 4:00 P.M. AT 871-6694 AND WE WILL SET UP AN APPOINTMENT TO COME AND SPEAK TO YOU.

OUR GOAL IS TO SERVE YOU!

SINCERELY,

ERIK S. ENERSEN  
CHIEF OF DEPARTMENT

81 So. Van Brunt Street | Englewood, NJ | 07631  
TEL 201-568-6301 FAX 201-568-1816

---

# GOOD MORNING CHECK-IN APPLICATION

Date of Application: \_\_\_\_\_

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Cross Street: \_\_\_\_\_

Doctor: \_\_\_\_\_

Phone #: \_\_\_\_\_

Name of Relative: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Medical Problems, if any:

---

---

Medications:

---

---

Location of House Key: \_\_\_\_\_

In the event the Fire Department cannot contact me and I have not notified them that I would be out of my home at 9:00 am, I do hereby give permission to the Englewood Fire Department to enter my residence at the above address in the best interest of my safety and well being.

Witness: \_\_\_\_\_

Signed: \_\_\_\_\_

Fire Department Personnel

Date: \_\_\_\_\_