



SUPPLEMENTAL 'AUTOMATIC LOCATION INFORMATION' (ALI) WORKSHEET

State of New Hampshire Department of Safety
Division of Emergency Services and Communications, Bureau of Emergency Communications
33 Hazen Drive, James H. Hayes Building, Concord, New Hampshire 03305
Phone: (603)271-6911 Fax: (603)271-6609 (fax) Digital form available on website: www.nh.gov/nh911

In all cases when the worksheet is filled out by someone other than the telephone subscriber, we will notify the telephone subscriber of the information to be contained within the Supplemental ALI database.

Check applicable box:

<input type="checkbox"/>	This is a new worksheet	<input type="checkbox"/>	This is a revision of a previously submitted worksheet	<input type="checkbox"/>	This is a request to delete
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Please Print or Type Clearly:

LINE 1 Subscriber's Landline/Wired Telephone Number ____ (____) ____ - ____

Subscriber's Cellular/Wireless Telephone Number __ (____) ____ - ____

LINE 2 Telephone Subscriber's Name: _____
Last First Middle Initial

LINE 3 Telephone Subscriber's Mailing Address: _____
Number Street

_____ NH _____
Town or City State Zip Code

LINE 4 Name of person(s) to whom this information refers (If Different from LINE 2):
A) _____
(Please Print)

B) _____
(Relationship to Telephone Subscriber - Please Print)

C) If information is regarding a child; please provide month and year of birth: _____

LINE 5 Name of person completing the form IF other than subscriber living at address:
A) _____
(Name of Person Completing Form - Please Print)

B) _____
(Relationship to Telephone Subscriber - Please Print)

C) _____
(Contact Person's Phone Number)

LINE 6 _____
(Signature of Person Completing Form)

Check all that apply and/or BRIEFLY state information as it should appear on the 9-1-1 computer screen in the event of an emergency (submit ONLY permanent medical conditions or hazardous material storage location). DO NOT include list of medications (unless life sustaining allergy medications or blood thinners) or physician information. PLEASE use language understood by all:

<input type="checkbox"/>	Deaf or Hard of Hearing (circle one)	<input type="checkbox"/>	Vision Impairment	<input type="checkbox"/>	Speech Impairment
<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	Autism	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Pacemaker or Heart Condition(circle one)	<input type="checkbox"/>	Developmental/Cognitive Disability	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Uses Wheelchair	<input type="checkbox"/>	Uses Oxygen	<input type="checkbox"/>	Hazardous Materials on Site

OTHER:

NOTE: A copy of this form will be mailed back to you via certified mail once it is entered into the database.

OFFICE USE: Entered into database on: _____ Initials: _____ Copy sent on: _____