

## EMERGENCY EVACUATION REPLY FORM

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

DUTY STATION: \_\_\_\_\_

SUPERVISOR \_\_\_\_\_

Please indicate whether you experience trouble in any of the following areas that might result in your needing assistance during an emergency situation:

Yes  No Limitations that interfere with walking or using the stairs (joint pain or mobility devices);

Yes  No Reduced stamina, fatigue, or tire easily (weight, age, or medical treatments);

Yes  No Respiratory problems (cardiac, asthma, or emphysema triggered by stress, dust, or smoke);

Yes  No Emotional, cognitive, thinking, or learning difficulties (anxiety disorder or confusion under stress);

Yes  No Vision or hearing loss; or

Yes  No Temporary limitations (surgery, accidents, pregnancy).

**If you have marked YES to any of the questions, but think you DO NOT need your own separate emergency plan, please indicate this and also have your supervisor sign:**

I do not require, or need, an individual evacuation plan. The facility plan is adequate for my needs.

\_\_\_\_\_  
Employee

\_\_\_\_\_  
Supervisor

Please return form to:  
Mary Knuth  
Disability Program Manager  
Office of Diversity and Civil Rights,  
303-236-4460 / Mail Stop: 60185 / Fax: 303-236-3816