Revere Commission on Disabilities

Clear Mask Distribution Questionnaire

1. Your name: __________________________________________________________

2. Address: __________________________________________________________

3. Email contact: _____________________________________________________

4. Phone contact: _____________________________________________________

5. Reason for this request: (choose or circle all that apply)

   ___ Self
   ___ I am the primary caregiver for an individual with / without special needs
   The person I care for is a: child (pre-school)    Adult
                        (school aged)

   Other Reason: ______________________________________________________

6. If you are the primary caregiver of a school aged child, which school does this child attend, and what grade level?
   Name of School / Grade: ____________________________________________

7. Any Additional Information you would like to share so that we may better assist you? (Please use back of page if needed)

   **Limited Quantity-While Supplies Available**

Please Email your completed form to Disabilities@revere.org. If you have any questions send us an email or contact the Disabilities office at 781-286-8267 and leave a message.

Thank you,
Revere Commission on Disabilities

(Questionnaire’s will be reviewed & if requirement needs are meet you will be contacted)