



PERS Data Information Sheet

Dealer Information

Dealer Number		Dealer Name	Date
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Subscriber Information	<input type="checkbox"/> Residential	<input type="checkbox"/> Commercial	<input type="checkbox"/> Commercial Fire	<input type="checkbox"/> Two-Way	<input type="checkbox"/> Medical Only	<input type="checkbox"/> UL Fire
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Account Number	Secondary Account Number	Subscriber Name
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Address (no P.O. Box)	Apt #.	City	State	Zip Code
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Premises Phone Number	Secondary Premises Phone Number	Cross Street	Subdivision	Map Grid
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	Authorities	24 Hour Emergency Number (not 911)	Permit Number
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PD			
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FD			
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MD			
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Guard			
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Test Frequency	If no test received notify Dealer via:	Communications		
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<input type="checkbox"/> None	<input type="checkbox"/> Event History	Standard Zone Template	Panel	Panel Phone #	Format
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<input type="checkbox"/> Daily	<input type="checkbox"/> Fax	Two-Way Panel Audible? Yes _____ No _____			
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<input type="checkbox"/> Weekly	<input type="checkbox"/> Email	Manual Reset of Cut off in _____ Minutes			
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<input type="checkbox"/> Monthly	<input type="checkbox"/> Telephone				
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Time Zone					
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<input type="checkbox"/> Atlantic	<input type="checkbox"/> Mountain				
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<input type="checkbox"/> Eastern	<input type="checkbox"/> Pacific				
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<input type="checkbox"/> Central	<input type="checkbox"/> Hawaii - Aleutian				
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Contact List Name	Telephone Number	Type*	Time Frame	Alternate Number	Type*	Subscriber Email
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1.						
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2.						
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3.						
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4.						
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* For "Type" above, please note MB = Mobile, HM = Home, WK = Work, OT = Other

Physician	Preferred Medical Facility/Hospital
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Name:	Name:
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Address:	Address:
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City, State, Zip:	City, State, Zip:
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Phone Number:	Phone Number:
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Date of Birth	Medical Information			
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/ /	<input type="checkbox"/> Impaired Vision	<input type="checkbox"/> Hard of Hearing	<input type="checkbox"/> Impaired Mobility	<input type="checkbox"/> Wheel Chair Bound
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MM/DD/YYYY	<input type="checkbox"/> Blind	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Cane	<input type="checkbox"/> Scooter
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Gender	<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Walker	
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<input type="checkbox"/> Female	Allergies			
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<input type="checkbox"/> Male				
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Language				
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Special Instructions				
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Key/Lockbox Location	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Notify on Power Fail	<input type="checkbox"/> DNR	
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	Other: _____			
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File of Life Location	_____			
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