



PERS Data Information Sheet

Dealer Information

Dealer Number	Dealer Name	Date
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Subscriber Information Residential Commercial Commercial Fire Two-Way Medical Only UL Fire

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"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	<input type="checkbox"/> Event History <input type="checkbox"/> Fax <input type="checkbox"/> Email <input type="checkbox"/> Telephone	Standard Zone Template	Panel	Panel Phone #	Format
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Time Zone		Two-Way Panel	Audible?	Yes _____ No _____
<input type="checkbox"/> Atlantic <input type="checkbox"/> Mountain <input type="checkbox"/> Eastern <input type="checkbox"/> Pacific <input type="checkbox"/> Central <input type="checkbox"/> Hawaii - Aleutian		Manual Reset of Cut off in _____ Minutes		

Contact List Name	Telephone Number	Type*	Time Frame	Alternate Number	Type*	Subscriber Email
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1.						
2.						
3.						
4.						

* For "Type" above, please note MB = Mobile, HM = Home, WK = Work, OT = Other

Physician	Preferred Medical Facility/Hospital
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Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone Number:	Phone Number:

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
MM/DD/YYYY	<input type="checkbox"/> Blind	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Cane	<input type="checkbox"/> Scooter
Gender	<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Walker	

<input type="checkbox"/> Female <input type="checkbox"/> Male	Allergies
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Language	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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File of Life Location	Other: _____
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