

Please fill out all fields below and return to Bay Alarm Medical via email, fax, or mail. **Please print clearly.**

User's First & Last Name	Email	DOB: MM/DD/YYYY	
Address	City	State	Zip
Cross Street (optional)	Preferred Language:		
Primary Phone	Secondary Phone		

Access to User's Residence: Describe how paramedics can gain access. Include location of any hidden keys, gate code(s), etc.

Lock box Code	Lock box Location
Gate Code	Garage Code
Home Security Alarm Code	Other Access Details

Emergency Call List: List the people that should be called during an emergency.

For the safety and protection of our customers, our dispatchers are NOT authorized to provide the Lock box Code to anyone other than 911 personnel. We encourage Call List Contacts to have an access plan.

Name (First & Last)	Relation to Subscriber/Patient	Phone Number	Type	Call before 911?	OK to Text?*
<i>please print clearly</i>	<i>neighbor, friend, etc.</i>	<i>please include area code</i>	<i>home, cell, etc.</i>	<i>yes or no</i>	<i>yes or no</i>
1.		()			
2.		()			

*Regular text messaging rates may apply. Please check with your carrier.

Vial of Life Instructions (VOL) We've included a Vial of Life kit with your medical alert system. The VOL contains your important medical information that can assist first responders in administering the proper medical treatment in case of an emergency.

Please follow the steps below:

1. Take out the VOL form from the plastic sleeve and fill out completely. Please make sure to print clearly. Feel free to use additional sheets of paper if necessary.
2. Re-insert the form into the plastic sleeve, secure the flap, and place somewhere accessible (Refrigerator door, nightstand, coffee table, etc.) Please confirm location of VOL below.
3. If relevant, include a copy of POLST/DNR insider sleeve with VOL.

Location of Vial of Life

I am the user of the Bay Alarm Medical Personal Emergency Response System. I have read the agreement terms and conditions which were provided with this information form, and pursuant to which Bay has agreed to provide the system and monitoring services, and understand and agree that I am bound by all of the terms and conditions, including the limitation of liability set forth in the paragraph titled "Bay is not an Insurer; Liquidated Damages; Limitation of Liability." In case of extreme emergency, I hereby authorize any licensed Physician to administer all emergency medical treatment deemed necessary (all adult family members must sign for themselves, responsible adults must sign for minors 17 years old and younger). I understand that it is my responsibility to complete and submit the Bay Alarm Medical Customer Information Form.

Signature _____ Parent Guardian Self Date MM/DD/YYYY