

Alarm ID:

<b>Client One</b>			
<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other:			
First Name:		Surname:	
Date of Birth:			
Street Address:			
Suburb:		State:	Post Code:
Email:			
Home Phone:		Mobile:	
<input type="checkbox"/> Lives alone   OR <input type="checkbox"/> Lives with:			
Language: <input type="checkbox"/> English <input type="checkbox"/> Other:		Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Access to your property in the case of an emergency:			
Keysafe location and code (if applicable):			
<b>Medical Information</b>			
<input type="checkbox"/> Diabetes Type One	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Diabetes Type Two	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> History of Stroke	<input type="checkbox"/> History of Falls
<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Mobility Problems	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Breathing Problems
Weight range: <input type="checkbox"/> Up to 70 kgs <input type="checkbox"/> 70 to 100 kgs <input type="checkbox"/> Over 100 kgs			
Health Conditions:			
Life Dependent Medication:			
Allergies:			
<b>Next of Kin</b>			
First Name:		Surname:	Home Phone:
Mobile:		Relationship to Client:	
<b>Client Two (if applicable)</b>			
<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Other:			
First Name:		Surname:	Date of Birth:
Relationship to Client One:		Is a Second Pendant required: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Medical Information</b>			
Weight Range: <input type="checkbox"/> Up to 70 kgs <input type="checkbox"/> 70 to 100 kgs <input type="checkbox"/> Over 100 kgs			
Health Conditions:			
Life Dependent Medication:			
Allergies:			

**Emergency Responders**

In priority order please list the details of people who have agreed to be contacted in the event that you require assistance.

Your nominated Responders should:

- Live within a reasonable distance
- Be contactable by phone
- Be willing to respond in the event of an emergency

Emergency services will be automatically added to your list of Responders.

**Emergency Responder One**

<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	<input type="checkbox"/> Miss	First Name:	Surname:
Street Address:					
Suburb:			State:	Post Code:	
Home Phone:		Mobile:		Work Phone:	
Email:					
Relationship to Client:			Travel time to Client:		
Available: <input type="checkbox"/> 24/7 <input type="checkbox"/> Day <input type="checkbox"/> Night			Does this Responder have access to a key: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Permission to give this Responder your Keysafe or access details if required: <input type="checkbox"/> Yes <input type="checkbox"/> No					

**Emergency Responder Two**

<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	<input type="checkbox"/> Miss	First Name:	Surname:
Street Address:					
Suburb:			State:	Post Code:	
Home Phone:		Mobile:		Work Phone:	
Email:					
Relationship to Client:			Travel time to Client:		
Available: <input type="checkbox"/> 24/7 <input type="checkbox"/> Day <input type="checkbox"/> Night			Does this Responder have access to a key: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Permission to give this Responder your Keysafe or access details if required: <input type="checkbox"/> Yes <input type="checkbox"/> No					

**Emergency Responder Three**

<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Ms	<input type="checkbox"/> Miss	First Name:	Surname:
Street Address:					
Suburb:			State:	Post Code:	
Home Phone:		Mobile:		Work Phone:	
Email:					
Relationship to Client:			Travel time to Client:		
Available: <input type="checkbox"/> 24/7 <input type="checkbox"/> Day <input type="checkbox"/> Night			Does this Responder have access to a key: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Permission to give this Responder your Keysafe or access details if required: <input type="checkbox"/> Yes <input type="checkbox"/> No					

<b>Equipment Options</b>			
<b>GPS Pendant</b> (only available to purchase)			
<input type="checkbox"/> Gem4 – GPS Pendant (recommended for Outdoor Use)			
<input type="checkbox"/> Neck Cord (option not available if you have a pacemaker)		<input type="checkbox"/> Belt Clip	<input type="checkbox"/> Keyring
<b>Alarm</b> (includes one standard pendant)			
<input type="checkbox"/> Purchase			
<input type="checkbox"/> Rent <i>*subject to availability</i>			
<b>Pendant</b>			
<input type="checkbox"/> Wrist Strap			
<input type="checkbox"/> Neck Cord			
<input type="checkbox"/> Additional Pendant/s – number of Additional Pendant/s:			
<b>Optional Accessories</b>			
<input type="checkbox"/> Keysafe			
<input type="checkbox"/> Extension Antenna <i>*required if you have poor mobile coverage in your area</i>			
<input type="checkbox"/> Purchase Falls Detector Pendant			
<b>Installation</b>			
<input type="checkbox"/> Self			
<input type="checkbox"/> Technician <i>*Conditions &amp; fees apply, not available in all areas, please call for more information</i>			
<b>Delivery of Equipment</b> <i>*only complete this section if the postal address is different to the client's address</i>			
First Name:		Surname:	
Address:			
Suburb:		State:	Post Code:
Home Phone:		Mobile:	
<b>Person Responsible for Payments</b>			
First Name:		Surname:	
Address:			
Suburb:		State:	Post Code:
Home Phone:		Mobile:	
Email:			
<b>Payment Options</b> <i>*if paying by direct debit, please complete the enclosed Direct Debit Request</i>			
<b>Upfront Costs</b>			
<input type="checkbox"/> Credit Card	<input type="checkbox"/> Direct Debit	<input type="checkbox"/> Cheque	<input type="checkbox"/> Cash
<b>Monthly Payments</b>			
<input type="checkbox"/> Invoice		<input type="checkbox"/> Direct Debit	
<b>Funded</b> (if applicable)			
<input type="checkbox"/> HCP	<input type="checkbox"/> Hospice	<input type="checkbox"/> Other:	

**Please ensure all parts of this form have been completed.**

You may return the Application Form and Direct Debit Request via one of the following options.

**WA**

In Person:	Post:	Email:
Silver Chain Alarms 6 Sundercombe Street OSBORNE PARK WA 6017	Silver Chain Alarms Reply Paid 65340 OSBORNE PARK WA 6017	alarms@silverchain.org.au

Information collected on this form will be shared with our monitoring centre, emergency services and installation subcontractors where necessary. It is important for you to contact us on 1300 557 551 if any of your personal, medical or emergency responders' details change at any time. We will contact you once we have received your Application Form.

**I have read and agree to the enclosed Terms of Supply**

**Full Name of Client or Authorised Representative** \_\_\_\_\_

**Signature of Client or Authorised Representative** \_\_\_\_\_

**Date** \_\_\_\_\_