Visual ✓erification
Monitoring Services

Notification of New Telecare Account Form

Service User Details			
Surname:		Forename(s)	
Tile:	MR ☐ MS ☐ MRS ☐ Other ☐		
Address			
Address			
City/Town			
County		Postcode:	
☎Telephone:		☎Mobile:	
✉ Email :			
Type of Residence:	Bungalow ☐ Apartment ☐ House ☐ Other ☐		
Keysafe Location:		Keysafe Code:	

Installation Company			
Company Name:		Contact Name:	
Address:			
☎Telephone:		🖷 Fax:	
E-mail Address: Required for delivery of Incident Reports and Activity Reports			
Accounts Department E-mail Address:			
Company to be Invoiced: (Please tick)	Installation Company ☐ Client ☐ Other ☐		
Device:		☎Telephone:	Serial Number

Respondents				
Priority	Name	☎Telephone Number	Mobile Number	Password
1				
2				
3				
4				

Local Police Service	
Area:	☎Telephone Number:

Local Fire Service	
Area:	☎Telephone Number:

Local Ambulance Service	
Area:	☎Telephone Number:

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To be completed by the Installation Company		
Installation Completion Date?		This system does ☐ does not ☐ comply with **DD CLC/TS 50134-7** (Please tick as applicable)
Police Unique Reference Number(s)		
Name:		Signature:
Date:		☎ Telephone:

To be completed by the Resident			
Medical Condition(s): e.g. Asthma, Heart Condition etc			
Medication: Heart Medication ☐ Insulin ☐ Inhalers ☐ Oxygen ☐ Warfarin ☐ Aspirin ☐ GTN Spray ☐ Morphine ☐ Other (Please specify below) ☐			
Location of Medication:			
Doctors Surgery:			
GP's Name:			
Address			
Address			
City/Town		**Postcode:**	
☎ Daytime:			
☎Out of Hours:			
Monitoring Commencement Date:			

Response Procedure	
Medical:	Audio ☐ Keyholder ☐ Ambulance Service ☐
Duress:	Audio ☐ Keyholder ☐ Police ☐
Fire:	Audio ☐ Keyholder ☐ Fire Service ☐
Intruder:	Audio ☐ Keyholder ☐ Police ☐

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Respondent 1			
Name:		Title	MR ☐ MS ☐ MRS ☐ Other ☐
Address			
Address			
City/Town			
County		Postcode:	
☎Telephone:		☎Mobile:	
✉ Email :			
Keyholder:	Yes ☐ No ☐	Next of Kin:	Yes ☐ No ☐
Authorised to receive medical/personal information: Yes ☐ No ☐			

Respondent 2			
Name:		Title	MR ☐ MS ☐ MRS ☐ Other ☐
Address			
Address			
City/Town			
County		Postcode:	
☎Telephone:		☎Mobile:	
✉ Email :			
Keyholder:	Yes ☐ No ☐	Next of Kin:	Yes ☐ No ☐
Authorised to receive medical/personal information: Yes ☐ No ☐			

Respondent 3			
Name:		Title	MR ☐ MS ☐ MRS ☐ Other ☐
Address			
Address			
City/Town			
County		Postcode:	
☎Telephone:		☎Mobile:	
✉ Email :			
Keyholder:	Yes ☐ No ☐	Next of Kin:	Yes ☐ No ☐
Authorised to receive medical/personal information: Yes ☐ No ☐			

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Respondent 4			
Name:		**Title**	**MR ☐ MS ☐ MRS ☐ Other ☐**
Address			
Address			
City/Town			
County		**Postcode:**	
☎Telephone:		**☎Mobile:**	
✉ Email :			
Keyholder:	**Yes ☐ No ☐**	**Next of Kin:**	**Yes ☐ No ☐**
Authorised to receive medical/personal information: Yes ☐ No ☐			

In order for the Visual Verification Ltd to carry out all its functions, relevant data may be disclosed, as deemed necessary, to emergency services responding to an alert from your property or to any of the Respondents who have been authorised above. You must advise us in writing if there is any change in your circumstances.

- I hereby declare that I have included any material fact in this document which would affect any response initiated by Visual Verification on receipt of an alert from my premises.
- I consent to Visual Verification disclosing medical/personal data to the emergency services or to persons authorised above in the event of an emergency alert from my system.
- I declare that all statements and information provided in the application are to the best of my knowledge and belief true and complete.

Resident Name:	
Signature:	**Date:**

Please note that telephone calls may be monitored and recorded to help staff training, customer service and for security purposes.

Internal Use Only					
Commission Date:		Commission Time:		Contract Start Date:	
Contract Issued			Site Details Complete		
Name:	Signature:		Name:		Signature:
Contract Number:					

Please return the completed form to: ✉ **ops@visualverification.com**
0844 415 9999