KNOX EMS CONTACT FORM

THE FOLLOWING INFORMATION IS REQUIRED:

Department Name:			
Street Address:			
Mailing Address (if different than the street address):			Phone: ( )
City:		County:	Fax: ( )
State:	Zip:	System Code:	Email:

DEPARTMENT HEAD

The officer in charge of your department's EMS Program.

Name:	Title:

KNOX EMS PROGRAM COORDINATOR

The Knox EMS Program Coordinator. All materials relating to the Knox EMS program will be sent to this person at the above address.

Name:	Title:
Phone:	Email:

AUTHORIZED SIGNATURES

Authorized signatures are required to order EMS Emergency Override Keys, delete or add names and authorized signatures for the EMS Program only.

These authorized signers **DO NOT** have the authority to request Knox Rapid Entry System Master Keys.

PRINT NAME AND TITLE	AUTHORIZED SIGNATURE Actual signatures are required to process the request(s)	DATE

MedVault Keys Quantity: _____

MedVault Override (check one)**:** ◯ Keyed Alike to System Code ◯ Noncombinated (Two keys ship with each unit)

Jurisdiction ◯ will ◯ will not use badge access

If **will** is marked, please complete the Credential Registration Form.

KNOX® When seconds matter®

UPON COMPLETION, SUBMIT THIS FORM VIA FAX OR MAIL - ATTN: RECORDS
Fax: 623.687.2296 | Knox Company, 1601 W. Deer Valley Rd., Phoenix, AZ 85027