Central California EMS Agency

NOTIFICATION OF DEFIBRILLATOR USE

To Be Completed by On-Site Contact and Submitted within 24 Hours of AED

Print and FAX to: (559) 600-7691, Attention: AED Coordinator

Name of Service Provider: ______________________________

Date of Occurrence: ______________

Time of Occurrence: ______________

Place of Occurrence (Address and Specific Location): ______________________

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Patient's Name: ______________________________

Patient's Age: ______________

Patient's Sex: ❍ M ❍ F

Did Anyone Witness the Collapse/Arrest? ❍ Yes ❍ No

Alert (time you were notified): ____________

Approximate Down Time Prior to You're Arrival: ____________

Was CPR Used Prior to AED of Victim? ❍ Yes ❍ No

Time of First Shock (if given): ____________

Total Number of Shocks: ____________

Did Victim Regain a Pulse at Scene? ❍ Yes ❍ No

Lay Responder Name(s): ______________________________

Name and Phone Number of Person Completing Form: ______________________

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Additional Comments/Information:

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