Emergency Medical Services

Public Safety/EMT AED Service Provider
AED Use Report

Provider Name: ____

Provider Agency: ____

Date of Incident: _________________________________ Time of Incident: ______________

Incident Address: _____________________________________ City: _________________________

Incident Number: _______________ (attach incident report/patient care report)

Patient Name: ____ (if available)

Arrest Witnessed (seen or heard): Y N

CPR done prior to your arrival: Y N

If yes: Compressions only

Compressions and ventilations

Circle one: **Shock** (number of shocks: _______) **No Shock**

Arrested prior to your arrival? Y N

Initial Rhythm: _______________________ (if known)

Please submit this report, with Patient Information attached, whenever an AED is used.

Submit to:
Contra Costa EMS Agency
Attn: Marshall Bennett
Marshall.Bennett@hsd.cccounty.us or fax: (925) 646-4379