CONTRA COSTA
HEALTH SERVICES

Emergency Medical Services

Emergency Medical Technician
AED Service Provider Application

Provider Name: _____

Contact Person: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ Fax: (_____)_____

Website: _____

Email: _____

Program Requirements:

- Authorize personnel and maintain a current listing of all EMT AED personnel and provide listing to EMS Agency upon request
- Provide orientation of authorized personnel to AED equipment
- Ensure maintenance of AED equipment
- Report the following data to the EMS Agency:
  - AED Use Report for each use of an AED by provider personnel
  - Annual summary of the number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care
  - Annual summary of the total number of patients on whom defibrillatory shocks were administered; witnessed (seen or heard) and not witnessed
  - Annual summary of the number of witnessed cardiac arrest patients (seen or heard) whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation (if known)

I certify that I/this agency will comply with all guidelines, regulations, policies and procedures related to being an EMT AED service provider. I certify that all information on this application, to the best of my knowledge, is true and correct.

_____ _____

Signature Date

Return to:
Contra Costa EMS Agency
1340 Arnold Drive, Suite 126
Martinez, CA 94553
Attn: Pam Dodson