

**Contra Costa County
EMS Agency**

Report of Automated External Defibrillator (AED) Use

Incident Information	Insert Information Here
Name of AED Service Provider Program (Business Name)	
Name of AED Provider (Who used the AED on a patient?)	
Was CPR performed prior to EMS arrival?	
Date Incident Occurred	
Time of Incident	
Patient's Name (if able to determine)	
Patient's Age (Estimate if unable to determine)	
Patient's Sex	
Do you want a follow-up from EMS with questions related to AED use? (provide contact details)	

1. **Keep this form as a MASTER**
2. **When the AED is used:**
 - i. **Complete the form with the appropriate information regarding the AED use**
 - ii. **Attach any additional information that you think would be helpful.**
3. **Return the completed form to the EMS Agency @ ems.event@hsd.cccounty.us within 24 hours of the use of the AED.**