



EMERGENCY MEDICAL SERVICES AGENCY

Event Notification of Usage of  
Automatic External Defibrillator

For use by (*circle one*) Fire Law Enforcement Lay Public  
School Health Club

|   |           |                 |                   |
|---|-----------|-----------------|-------------------|
| Name of AED Service Provider Agency/Organization: * |           |                 |                   |
| Location of Event: *                                |           |                 |                   |
| City/State/ZIP: *                                   |           |                 |                   |
| Date and time of event                              |           |                 |                   |
| Reporting Party Name:                               |           | Telephone #:    |                   |
| Date and time of Event                              |           |                 |                   |
| If known:   | Name      | Approximate Age | Gender            |
| Was 911 called?                                     | Yes       | No              |                   |
| Was event witnessed or not-witnessed?               | Witnessed |                 | Not Witnessed     |
| Was pulse checked at initial assessment?            |           |                 |                   |
| Was CPR initiated before AED arrived?               | Yes       | No              |                   |
| Were shocks delivered?                              | Yes       | No              | if yes, how many? |
| Did patient :                                       |           |                 |                   |
| Regain a pulse?                                     | Yes       | No              |                   |
| Resume breathing?                                   | Yes       | No              |                   |
| Regain consciousness?                               | Yes       | No              |                   |
| Transporting Ambulance Provider and Unit#           |           |                 |                   |

Please share any problems encountered

**Reporting Instructions:**

- Please submit this report within 24hrs of the event to Mountain Counties EMS Agency
- AED usage is **whenever pads have been placed** on the patient whether a shock was delivered or not

Name of person completing the form if different than reporting party:

\_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Within 24 hrs. his form must be submitted to:

Mountain Counties EMS Agency  
3505 Spangler Ln. #405  
Copperopolis, CA 95228  
Attn: Usage Notification AED  
FAX: 209-529-1496

Or

[dutyofficer@mvemsa.com](mailto:dutyofficer@mvemsa.com)