



Application for Installation of
Automatic External Defibrillator
For use By Service Provider Agency

Name of Agency/Organization: *
Physical Address: *
City/State/ZIP: *
Contact Name: *
Telephone #: *
AED Manufacturer/Model: *
Serial Number(s) : *
of AEDs being placed into service: *
Location(s) of AEDs: *
Authority: CA Health & Safety Code, Division 2.5 California Code of Regulations, Title 22, Division 9, Chapter 2.3 Section 100027.05
EMS Prehospital Service Provider Agencies desiring to provide AED services to the general public shall submit the following required documentation in writing on company letterhead for the application process to be approved by Mountain Counties EMS Agency:
<ul style="list-style-type: none">• Organization name, address and contact information• Description of the organization's AED equipment orientation training for PSFA, EMR and/or EMT personnel.• Description of the organization's AED equipment maintenance program.• Description of the organization's procedures for collection and retention of AED utilization medical records.• Description of the organization's quality improvement (QI) monitoring and oversight processes related to AED utilization.

form continued on next page

Provider Agency shall adhere to the following:

- Approved AED Service provider shall continually comply with MCEMSA Agency Policy # 418.00 AED Service Providers
- The AED(s) is (are) maintained and regularly tested according to the operation and maintenance guidelines set forth by the manufacturer.
- Ensure that the AED is tested at least bi-annually and after each use.
- Ensure that an inspection is made of all AEDs on the premises at least every 30 days for potential issues related to operability of the device(s), including a blinking light or other obvious defect that may suggest tampering or that another problem has arisen with the functionality of the AED.
- Ensure that records of the maintenance and testing required pursuant to this paragraph are maintained.
- Submit an Event Notification to MCEMSA within 24 hours whenever the AED is deployed to and utilized in providing patient care to a specific individual
- I hereby certify that all information on this form is true and correct

Authorized Signature: _____ Date _____

This form must be submitted to:

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