Health Club
Automatic External Defibrillation (AED) Use Report

This form is to be completed every time a Health Club's AED is applied to a patient. It is the responsibility of the Health Club's AED Site Coordinator or designee to complete and FAX this form to San Mateo County EMS Agency (650) 573-2029 within 24 hrs. Thank you.

Name:_____

Date of Incident:_____/_____/_____Time of Incident:_____

Location of Incident:_____

Name of Person Applying AED:_____

Was the cardiac arrest witnessed by anyone? Yes ( ) No ( )

Who witnessed (e.g. bystander, staff member, other)?

_____

Was CPR started prior to AED? Yes ( ) No ( )

Who stared CPR? Staff ( ) Bystander ( ) Other ( )

Did AED deliver a shock? Yes ( ) No ( )

If so, how many times did the machine deliver a shock?_____

Patient care turned over to: Fire Agency _____

Ambulance_____

Person Completing this Form:_____

Agency:_____Phone No._____