AED SERVICE PROVIDER ANNUAL REPORT

As required by State law and local policies, the following statistical information is required on an annual basis, due by March 31st for the previous calendar year.

AED Service Provider Name: _______________________________________________________
Reporting period: ________________________________________________________________

1. Population served (estimate): __________________

2. Number of responses to patients where an AED was used initially: __________
   (To include initial AED use only, including use before ALS arrival. DO NOT include responses where only paramedic/ALS manual defibrillation was used. This information will be captured in the patient care records for ALS responses.)

3. Number of resuscitations attempted: __________

4. Number of resuscitations not attempted: __________
   Ref. No. 814, Determination/Pronouncement of Death in the Field, valid Do-Not-Resuscitate (DNR), Advanced Health Care Directive (AHCD), Physicians Orders for Life Sustaining Treatment (POLST), personal physician, or family at scene requesting to withholding resuscitation efforts.

5. Number of patients on whom an AED was applied: __________

6. Total number WITNESSED arrest (seen or heard by AED provider personnel): __________
   a) Number who received bystander CPR prior to arrival of emergency medical care __________
   b) Number with initial rhythm of V-Fib or V-Tach (AED indicated shock advised with initial application) __________
   c) Number who received a shock from an AED operated by the AED service provider __________

7. Total number UNWITNESSED arrest (prior to arrival of AED provider personnel): __________
   a) Number who received bystander CPR prior to arrival of emergency medical care __________
   b) Number with initial rhythm of V-Fib or V-Tach (AED indicated shock advised with initial application) __________
   c) Number who received a shock from an AED operated by the AED service provider __________
8. Problems associated with AED operation or application: □ Yes □ No
   If you answered yes, check appropriate box below and provide additional information.
   a) Equipment failure
      Machine shocks rhythm other than V-Fib or V-Tach □
      No discharge □
      Tape/Battery Malfunction □
      Other □
      __________________________
      __________________________
      __________________________
   b) Lack of skill proficiency □ Yes □ No
      __________________________
      __________________________
      __________________________

9. Name of MD, RN, PA, or Paramedic primary reviewer of AED application (s):
   __________________________
   __________________________
   __________________________
   Contact number: _______________ Email address: _______________

10. Manufacturer/Model of the AEDs: __________________________
    Number of AEDs in Service: ____________ Pediatric Pads □ Yes □ No

11. Number of personnel by level authorized to use AEDs within your agency:
    a) EMT: ___________
    b) Public Safety personnel (Non-EMT): ___________
       (Peace Officers, Lifeguards and Firefighters)
    c) Non-licensed/non-certified personnel: ___________
       (Lay public/employees)

12. Frequency of individual AED/CPR skills competency verification:
    □ Every 2 years (EMT only) □ Annually □ Every 6 months □ Other: ___________
    __________________________
    __________________________
    __________________________

AED Program Coordinator: ____________________________ Title: _______________________
Email: ____________________________ Contact Number: _________________________
AED Program Coordinator’s Signature: ____________________________ Date: ___________

Submit report via mail, e-mail or fax to:

Los Angeles County EMS Agency
Attn: AED Coordinator
10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670
e-mail: aedprograms@dhs.lacounty.gov
Fax: (562) 941-5835