AED SERVICE PROVIDER ANNUAL REPORT

As required by State law and local polices, 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