**Los Angeles County EMS Agency**
**Attn: AED Program Coordinator**
**10100 Pioneer Blvd, Suite 200**
**Santa Fe Springs, CA 90670**
**Tel: (562) 347-1500 Fax: (562) 941-5835**

# PAD Post Event Report

***After each use of the AED, by law you must send a report to the EMS Agency.***
***Complete as much information as possible and submit by mail or fax within 72 hours***

| **Date of Incident:** | **Time of Incident:** | **Team/Shift/Unit:** | | **Name of person who applied AED:** |
|---|---|---|---|---|
| **Time 911 called:** | **Time 911 arrived:** | **Name of 911 Agency:** | | ☐ **Fire Dept** ☐ **Law Enforcement** ☐ **Other** |
| **Victim's Name:** | | **Date of Birth:** | **Age:** | **Sex:** Male ☐ Female ☐ |
| **Victim's Address:** | | | | |

Location of Incident: Home ☐ Work ☐ Public Place ☐ Healthcare Facility ☐ Other ☐ ______________
Address of incident: ______________________________________________________________

Witnessed Arrest (seen or heard)? Yes ☐ No ☐ Witnessed by Whom: ___________________________
Approximate "down" time: ________________

Signs of Injury? Yes ☐ No ☐ If yes, please explain:

Bystander CPR administered? Yes ☐ No ☐ If yes, Name(s):______________________________________

Position victim was found in (i.e. lying, sitting): _____________________________________________

Total number of shocks delivered: ____________ Did victim regain a pulse? Yes ☐ No ☐

Name of 911 Agency who took over care of victim: ______________________________________

Time: ________

Equipment failure / problems? Yes ☐ No ☐ If so, explain: _________________________________

Completed by: ______________________________ Title: ____________________ Date: _______________

Contact #: ________________________________________ Report sent to EMS Agency: Yes ☐ No ☐