



## AED SERVICE PROVIDER ANNUAL REPORT

January 1 through December 31, 2011

As required by State law and local polices, the following statistical information is required annually.  
**Deadline for submission is March 31, 2012.**

AED Service Provider Name \_\_\_\_\_

1. Population served (estimated): \_\_\_\_\_

2. Number of ALS and/or BLS) responses to patients who suffered sudden cardiac arrest: \_\_\_\_\_

Number of resuscitations attempted: \_\_\_\_\_

Number not attempted \_\_\_\_\_

- Patient met Reference No. 814 criteria, valid DNR or AHCD provided, patient's personal physician or family members at scene request withholding resuscitation efforts.

3. Number of patients on whom an AED was applied: \_\_\_\_\_

4. AED Shocks given:  **YES - Complete entire form including the table**     **NO - Go to section 8 on page 2)**

5. Total number of patients who received defibrillatory shocks from an AED: \_\_\_\_\_

Adult \_\_\_\_\_ Child (8-17) \_\_\_\_\_ Child (1-7) \_\_\_\_\_ Infant (< 1 year): \_\_\_\_\_

### COMPLETE TABLE ONLY FOR PATIENTS WHO WERE SHOCKED BY YOUR AED

Total number witnessed arrest	Number with Bystander CPR	Number who regained pulse prior to ALS care	Number with initial rhythm of V-fib or V-tach	Number discharged alive	Number discharged alive with neuro status unchanged
				<input type="checkbox"/> Info Unavailable	<input type="checkbox"/> Info Unavailable
Total number unwitnessed arrest	Number with Bystander CPR	Number who regained pulse prior to ALS care	Number with initial rhythm of V-fib or V-tach	Number discharged alive	Number discharged alive with neuro status unchanged
				<input type="checkbox"/> Info Unavailable	<input type="checkbox"/> Info Unavailable

6. Problems associated with AED operation  **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**

\_\_\_\_\_

\_\_\_\_\_

7. Name of MD, RN, PA or Paramedic who reviewed AED use(s): \_\_\_\_\_  
*If more than 1 person, list the main reviewer*

Contact number: \_\_\_\_\_ Email address: \_\_\_\_\_

8. Manufacturer/Model of AEDs: \_\_\_\_\_ No. of AEDs in service: \_\_\_\_ Peds:

9. Number/level of personnel authorized to use AEDs within your agency:

a. BLS Providers (EMTs): \_\_\_\_\_

b. Public Safety Personnel:  
(Peace officers, lifeguards and **non** EMT firefighters) \_\_\_\_\_

c. Non-licensed/non-certified persons:  
(Lay public/employees) \_\_\_\_\_

10. Frequency of individual AED skill proficiency demonstration:

**Every 2 years (EMT only)**  **Annually**  **Every 6 months** **Other:** \_\_\_\_\_

AED Program Coordinator: \_\_\_\_\_

Title: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Email: \_\_\_\_\_

AED Program Coordinator's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Mail or fax this report to:**

**Los Angeles County EMS Agency  
Attn: AED Coordinator  
10100 Pioneer Blvd, Suite 200  
Santa Fe Springs, CA 90670**

**Fax number: (562) 941-5835**