

Appendix D

King County CPR-AED Community Responder Program

Site Documentation Form

Please check one:

- Request Medical Direction to purchase an Automated External Defibrillator (AED)**
I would like to purchase an Automated External Defibrillator and request medical oversight.
- Request Medical oversight of AED Program**
I currently have an Automated External Defibrillator and would like to obtain medical oversight.
- Request Registration of an Automated External Defibrillator (AED)**
I currently have an Automated External Defibrillator and medical oversight and would like to register the device.
 Medical Director: _____ Program Name: _____
- Request to update information**
My device is registered with King County EMS and I would like to update my site information.

Customer Information: Please PRINT LEGIBLY

****Required Information**

**Company or; _____ <i>If Private Resident list</i>		
**Customer Name: _____ First Name Last Name		
Business Type: (Ex: Law offices, School, Manufacturer, Public pool) _____		
**Physical Address:		
Address 1: _____ Street Address Suite/Apt #		
Address 2: _____ Street Address Suite/Apt #		
City, State, Zip: _____ City State Zip		
**Mailing Address: <input type="checkbox"/> Same as Physical Address		
Address 1: _____ Street Address Suite/Apt #		
Address 2: _____ Street Address Suite/Apt #		
City, State, Zip: _____ City State Zip		
Days of Operation: <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun <input type="checkbox"/> 7days/Week <i>Please check all that apply</i>		
Hours of Operation: _____ <input type="checkbox"/> 24/7 (Ex: Private Residence, 24hr Business) Start Time End Time		

Contact Information: If you have more than one site coordinator, please use a blank sheet to provide the following Contact information for each Site Coordinator and Site Manager. Please identify the AED # or Location of device he/she is responsible for.

**1st Contact: List your Site Coordinator		**2nd Contact: List your Supervisor	
Name _____ First Last		Name _____ First Last	
Title _____		Title _____	
Phone _____		Phone _____	
Cell _____		Cell _____	
Email _____		Email _____	

Training Information:

Training Program: Ex: American Heart Assoc., American Red Cross _____	
Number of People trained: _____	Date initial Training completed: _____

****Total Number of AED's:** _____ *If you have more than one device please use the section below to list each device individually. Please use additionally copies of this form or blank sheets to record a complete list of your devices.*

AED #1 Serial # _____ **Date AED put into operation** _____

****Make** _____ ****Model** _____

Location of the Device: Same as Physical Address

Address 1: _____
Street Address Suite/Apt #

Address 2: _____
Street Address Suite/Apt #

City, State, Zip: _____
City State Zip

Number of Employees at this location _____ **Number of Vistors** _____ **Private Residence:** *List number of people who reside at this location* _____

Placement of the Device: *Describe the approximate location your device is placed in your home, business or vehicle:*

Site Visit Completed by: _____
First Name Last Name Agency

Date of Site Visit: _____ **Local Fire Dept:** *List the name of the Fire Dept that responds to your location.*

AED #2 Serial # _____ **Date AED put into operation** _____

****Make** _____ ****Model** _____

Location of the Device: Same as Physical Address

Address 1: _____
Street Address Suite/Apt #

Address 2: _____
Street Address Suite/Apt #

City, State, Zip: _____
City State Zip

Number of Employees at this location _____ **Number of Vistors** _____ **Private Residence:** *List number of people who reside at this location* _____

Placement of the Device: *Describe the approximate location your device is placed in your home, business or vehicle:*

Site Visit Completed by: _____
First Name Last Name Agency

Date of Site Visit: _____ **Local Fire Dept:** *List the name of the Fire Dept that responds to your location.*

AED #3 Serial # _____ **Date AED put into operation** _____

****Make** _____ ****Model** _____

Location of the Device: Same as Physical Address

Address 1: _____
Street Address Suite/Apt #

Address 2: _____
Street Address Suite/Apt #

City, State, Zip: _____
City State Zip

Number of Employees at this location _____ **Number of Vistors** _____ **Private Residence:** *List number of people who reside at this location* _____

Placement of the Device: *Describe the approximate location your device is placed in your home, business or vehicle:*

Site Visit Completed by: _____
First Name Last Name Agency

Date of Site Visit: _____ **Local Fire Dept:** *List the name of the Fire Dept that responds to your location.*

