Public Access
Automatic External Defibrillation (AED) Use Report

This form is to be completed every time a public access AED is applied to a patient. It is the responsibility of the AED Site Coordinator or designee to complete and FAX this form to San Mateo County EMS Agency (650) 573-2029 within 24 hours. Thank you.

Agency:_______________________________________________________________

Date of Incident:_____/_____/_______Time of Incident:_______________

Location of Incident:_________________________________________________

Name of Person Applying AED:______________________________________

Was the cardiac arrest witnessed by anyone? Yes (   ) No (   )

Who witnessed (e.g. bystander, employee, security guard)?
_____________________________________________________________________

Was CPR started prior to AED? Yes (   ) No (   )

Who stared CPR? (  ) Bystander (  ) Employee ( ) Other (  )

Did AED deliver a shock? Yes (   ) No (   )

If so, how many times did the machine deliver a shock?__________

Patient care turned over to: Fire Agency__________

Ambulance__________

Person Completing this Form:__________________________________________

Agency:____________________________________Phone No.________________