AED Authorization

Description

- ## Automatic External Defibrillator (AED) Authorization Form

- AED Authorization Form Type
  - ☐ New Registration
  - ☐ Status Update

- ## AED Owner

  Provide information of the Department that own the AED unit
- Department(Required)
- Chair/Director Name
  First Last
- Title
- Department Address
  Street Address Address Line 2
  City State / Province / Region
  ZIP / Postal Code
- Phone
- Email

- ## Primary Department Coordinator

  List the primary contact responsible of the AED unit
- Name(Required)
  First Last
- Title
- Address(Required)
  Street Address Address Line 2
  City State / Province / Region
  ZIP / Postal Code
- Email(Required)
- Phone(Required)

- ## Alternate Department Coordinator

  List alternate contacts responsible of the AED unit
-

Name(Required)

First Last

- Title
- Email(Required)
- Phone(Required)
- I want this contact person to receive AED notifications
  - ☐ Enable Notifications
- Name

  First Last
- Title
- Email
- Phone
- I want this person to receive AED notifications
  - ☐ Enable Notifications

- ## AED Identification

  Provide information of the AED unit
- Date unit was purchased(Required)

  MM slash DD slash YYYY
- Date unit was installed

  MM slash DD slash YYYY
- AED Location (provide a description(Required)
- Building(Required)
- Room Number(Required)
- Floor Number(Required)
- Manufacturer(Required)
- Model(Required)
- Serial Number(Required)
- Battery Expiration Date(Required)

  MM slash DD slash YYYY
- Spare Battery Expiration Date

  MM slash DD slash YYYY
- Adult Pads Expiration Date(Required)

  MM slash DD slash YYYY
- Spare Adult Pads Expiration Date

  MM slash DD slash YYYY
- Pediatric Pads Expiration Date

  MM slash DD slash YYYY
- Spare Pediatric Pads Expiration Date

  MM slash DD slash YYYY

- ## Training Certification

  Department coordinator is highly encouraged to provide appropriate training to each user.

Training in CPR & AED

- Name
  ____________________ First ____________________ Last
- Title ____________________
- Training Expiration Date
  ____________________ MM slash DD slash YYYY
- Email
- Phone
- Name
  ____________________ First ____________________ Last
- Title ____________________
- Training Expiration Date
  ____________________ MM slash DD slash YYYY
- Email
- Phone
- Name
  ____________________ First ____________________ Last
- Title ____________________
- Training Expiration Date
  ____________________ MM slash DD slash YYYY
- Email
- Phone

- ## Quality Assurance Program

Provide information of your communication plan and preventative maintenance program

- AED manual(s) and additional information are available at ____________________
- Describe the communication plan for advising building occupants of the presence and locations(s) of AEDs ____________________
- Describe how internal notification of an emergency, including how AED Responders will be contacted ____________________
- Event Tracking/Reporting - Upon use the EMS system must be notified promptly. Person responsible for notification UFPD and EHS
- Per manufacturer's guidelines, must be maintained and tested. Preventative maintenance (PM) procedures that check the status of the battery, the condition and expiration of the padsd as well as other items that may be specified by the manufacturer. These items should be checked a minimum of monthly basis or based on manufacturer's recommendation.
- Name(Required)
  ____________________ First ____________________ Last
- Title ____________________
- Type of reporting
  - ☐ Written
  - ☐ Online
  - ☐ Both
- Frequency
  - ☐ Daily

- ☐ Weekly
- ☐ Monthly

- Program Updates
  - ☐ Review and update of this program will be performed annually by the AED Department Coordinator and report to EHS if update is needed.

- ## Acknowledge

  By signing below, I certify that this information is true and correct toe h best of my knowledge.
- Primary Coordinator Name(Required)
  ________________ First ________________ Last
- Signature(Required)
- Date(Required)
  ________________ MM slash DD slash YYYY
- Department/Chair Name
  ________________ First ________________ Last
- Signature
- Date
  ________________ MM slash DD slash YYYY
- Comments
  ____
  This field is for validation purposes and should be left unchanged.

Submit