



**Public Access Defibrillation (PAD)  
AED Use Notification  
EMS 915**

***Directions:***

- Please use one form for each AED Use
- Submit to the Santa Clara County EMS Agency

**AED Program Name:**

\_\_\_\_\_

**Incident Information**

Date: \_\_\_\_\_ Time of Incident: \_\_\_\_\_

Street Address: \_\_\_\_\_

Patients Name (if known): \_\_\_\_\_

Patients Estimated Age: \_\_\_\_\_ Patients Sex: \_\_\_\_\_

Was CPR performed?: \_\_\_\_\_ CPR

Provider: \_\_\_\_\_

What was the total number of defibrillations delivered? \_\_\_\_\_

**Times**

Witnessed Arrest	
Start of CPR	
Call to 911	
First Defibrillation	
911 Arrival On the Scene	

PAD Program Medical Director Signature: \_\_\_\_\_

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