

**Contra Costa County
EMS Agency**

Report of Automated External Defibrillator (AED) Use

Incident Information	Insert Information Here
Name of AED Service Provider Program (Business Name)	
Name of AED Provider (Who used the AED on a patient?)	
Date Incident Occurred	
Time of Incident	
Patient's Name (if able to determine)	
Patient's Age (Estimate if unable to determine)	
Patient's Sex	

1. **When the AED is used, copy this form, complete the information.**
2. **Please attach any additional information that you think would be helpful.**
3. **Return this form to the EMS Agency within 24 hours of the use of the AED.**

Fax # (925) 646-4379
Attn: PAD Program Coordinator