

Notice of Intent to Provide Public Access Defibrillation

Original Notification Update

Entity Providing PAD

Name of Organization	() Telephone Number
Name of Primary Contact Person	E-Mail Address
Address	() Fax Number
City State Zip	

Type of Entity (please check the appropriate boxes)

<input type="checkbox"/>	Business	<input type="checkbox"/>	Fire Department/District	<input type="checkbox"/>	Private School
<input type="checkbox"/>	Construction Company	<input type="checkbox"/>	Police Department	<input type="checkbox"/>	College/University
<input type="checkbox"/>	Health Club/ Gym	<input type="checkbox"/>	Local Municipal Government	<input type="checkbox"/>	Physician's Office
<input type="checkbox"/>	Recreational Facility	<input type="checkbox"/>	County Government	<input type="checkbox"/>	Dental Office or Clinic
<input type="checkbox"/>	Industrial Setting	<input type="checkbox"/>	State Government	<input type="checkbox"/>	Adult Care Facility
<input type="checkbox"/>	Retail Setting	<input type="checkbox"/>	Public Utilities	<input type="checkbox"/>	Mental Health Office or Clinic
<input type="checkbox"/>	Transportation Hub	<input type="checkbox"/>	Public School K – 6	<input type="checkbox"/>	Other Medical Facility (specify)
<input type="checkbox"/>	Restaurant	<input type="checkbox"/>	Public School 6 - 12	<input type="checkbox"/>	Other (specify)

PAD Training Program (Indicate the training program chosen. Only the approved programs may be used. Please see Policy Statement 09-03 [<http://www.health.state.ny.us/nysdoh/ems/policy/09-03.htm>])

--

Automated External Defibrillator

Manufacturer of AED Unit	Model of AED Pediatric Capable	Is the AED Pediatric Capable? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Trained PAD Providers	Number of AEDs
--------------------------	--------------------------------	--	---------------------------------	----------------

Emergency Health Care Provider

Name of Emergency Health Care Provider (Hospital or Physician)	Telephone Number
Address	() Fax Number
City State Zip	

Name of Ambulance Service and 911 Dispatch Center

Name of Ambulance Service and Contact Person	Telephone Number
Name of 911 Dispatch Center and Contact Person	County

Authorization Names and Signatures

CEO or Designee (Please print)	Signature	Date
Physician or Hospital Representative (Please print)	Signature	Date

County:

Location of AED(s) in your facility:

Did you purchase the software to download the AED?

Yes

No

Do you have a sign posted outside of your building noting the location of your AED?
(Required by law regardless if AED is accessible by others outside of entity).

Yes

No

If not, you can download signs ready to print at our website: <https://mlrems.org/community/forms>