

AED INCIDENT REPORT FORM

Section 1: Incident Information

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|--|---------------------|
| Date of Incident: | ____/____/____ |
| Time of Incident: | ____:____ A.M./P.M. |
| Location of Victim: | |
| Name and Phone Contact Number of First Responder: | |
| Name and Phone Contact Number of Person Activating EMS (911): | |
| Time EMS notified: | ____:____ A.M./P.M. |
| Time EMS responded: | ____:____ A.M./P.M. |
| Name(s) and Phone Contact Number(s) of Any Assisting First Aid Responders: | |

Section 2: Victim Information

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|---|------------------------------------|
| Name of Victim: | |
| Victim's Approximate Age: | |
| Briefly Describe Incident: | |
| Time AED pads applied: | ____:____ A.M./P.M. |
| Time CPR initiated: | ____:____ A.M./P.M. |
| Date and Time District Office Notified: | ____/____/____ ____:____ A.M./P.M. |

Section 3: Signature

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|---|--|
| Printed Name of person completing this form: | |
| Signature of person completing this form: | |
| Date: | |