



**Automated Defibrillation Notification**  
**Vermont Department of Health**  
(Please print legibly)



Name of Organization: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Mailing City/State/Zip: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Physical City/State/Zip: \_\_\_\_\_

Contact Person Name: \_\_\_\_\_

Contact Person Telephone: \_\_\_\_\_

Contact Person E-mail: \_\_\_\_\_

Brand of Automated Defibrillator(s) Purchased: \_\_\_\_\_

Number of Automated Defibrillator(s) Purchased: \_\_\_\_\_

Specific building location(s) of the Automated Defibrillator(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date the defibrillator was placed in operation: \_\_\_\_\_

Has training taken place? Yes No If not, why? \_\_\_\_\_

\_\_\_\_\_

VT statute also requires notification of the ambulance or first responder service providing emergency coverage to your location. A copy of this form may be sent to them. If you are not certain about which agency provides coverage to your location, please contact us for assistance.

As the contact person for this organization, we will maintain the automated defibrillator(s) under our control in accordance with the applicable standards of the manufacturer and will notify emergency medical services responders through the 9-1-1 system whenever an automated defibrillator is used:

\_\_\_\_\_

Signed

\_\_\_\_\_

Date

Return this form to: Vermont Department of Health  
DEPRIP - EMS Office  
Box 70, 108 Cherry St.  
Burlington, VT 05402

800-244-0911 (within VT) or 802-863-7310  
fax: 802-863-7577

[vtems@vermont.gov](mailto:vtems@vermont.gov)  
[www.vermontems.org](http://www.vermontems.org)