Automated Defibrillation Notification
Vermont Department of Health

Name of Organization: ______________________________

Mailing Address: ______________________________

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 location of the Automated Defibrillator(s): ____________________

____

____

Date the defibrillator was placed in operation: ____________________

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
EMS Office
Box 70, 108 Cherry St.
Burlington, VT 05402

800-244-0911 or 802-863-7310 fax: 802-863-7577 www.state.vt.us/health/ems