

Keep the Beat Alive Public Access Defibrillation

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Participation in the Austin / Travis County Public Access Defibrillation Program *[Document A]*

1. Organization name : _____
2. AED Contact Person: _____
3. Contact street address: _____
4. Contact City, State & Zip: _____
5. Contact Telephone: _____ Contact Fax: _____
6. Contact E-mail: _____
7. Medical Director: _____ Phone: _____
(if other than Austin – Travis County EMS System)
Address _____
8. Defibrillator model(s) used: _____
9. Training program(s) used: ___ AHA ___ Red Cross ___ NSC ___ Other
10. Note physical location of AED(s) (Document B - AED Location Form)
11. Review & sign defibrillation initiative requirements for Medical Direction by The Medical Director of the Austin – Travis County Emergency Medical Services System.
(Document C – Medical Oversight)

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AED Location Form (for all AEDs) *[Document B]*

• Site Name _____

Street Address _____

City, State & Zip _____

AED Location(s)
(be very specific) _____

• Site Name _____

Street Address _____

City, State & Zip _____

AED Location(s)
(be very specific) _____

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AED Program Medical Oversight Requirements ***[Document C]***

Participation in the Austin / Travis County Public Access Defibrillation Program is voluntary. The Austin / Travis County EMS Medical Director will provide voluntary physician oversight for AED programs in Travis County under the following conditions:

The organization(s) and individual(s) participating in the program agree to:

- Notify the Medical Director or the AED Coordinator for the following:
 - Acquisition of new AED (note – this satisfies requirement to notify EMS)
 - Any application of the AED on a patient
 - Any change in AED Contact information or placement
 - Any malfunction of the AED
- Users must remain current in CPR & AED training as provided by the American Heart Association, American Red Cross or National Safety Council or other approved courses.
- Maintain all AEDs according to manufacturer's guidelines
- Immediately activating 911 when AED is applied to any patient

Signature

Title

Date