



AGENCY APPLICATION – AUTOMATED DEFIBRILLATION PROGRAM

ATTACHMENT - A

(Use the back of this sheet, or attach additional sheets if needed to fully answer questions!)

1. Person Making Application/Contact Person For AED Program: _____

2. Name of AED Service: _____ Date of Application: _____

3. Base Address of Service: _____
(Street, Route, Apt. #) (City) (County) (Zip Code)

4. Telephone #: _____ Fax #: _____ Email: _____

5. AED Program's Medical Director: _____ Georgia License #: _____
(PLEASE PRINT) (Last) (First) (M.I.)

6. **ANNUAL CERTIFICATION STANDARDS:** All Designated AED Providers participating in a licensed AED Program must be certified annually to use the Automated Defibrillator. State your plan to meet the initial certification of all Agency Personnel as well as the annual re-certification requirement for all Agency Personnel: _____

7. **USE OF AED PROTOCOL:** All licensed AED Programs in the State of Georgia MUST have a standardized Protocol for use of the AED that conforms to standards set by either the American Heart Association, the American Red Cross, or other standard AED Protocol as approved by DHR. This AED Protocol for use of the device must also be approved and signed by the licensed AED Program's Medical Director. A copy of the protocol to be used by this AED Program MUST be attached to this application.

8. **DOCUMENTATION OF REVIEW:** Please state the process by which your AED Program will review the use of the AED device and how it will be documented: _____

9. **MAINTENANCE:** The Automated Defibrillator must be properly maintained. State your AED Program's plan to make sure the defibrillator is always in working condition: _____

10. **PERSONNEL:** Attach a list in the following format of the personnel in your AED Program who have successfully completed a proficiency test in one of the DHR approved AED Training Programs for use of the Automated Defibrillator and who qualify for certification in your licensed AED Program:

NAME (Print)	State Level of EMS Certification and/or Training	FR, EMT-B, EMT, CT or Pmdc. #
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____

This list of AED certified personnel in your licensed AED Program MUST be certified with the following statement at the end: *I certify that the individuals named above have met the minimum standard requirements set forth by DHR to use the Automated Defibrillator and that all protocols as approved and set forth by DHR are in use by this licensed AED Program.*

(AED Program Medical Director – Please Print) (Signature of AED Program Medical Director) (Date)

11. The Region _____ EMS Council recommends approval of this Automated Defibrillation Program.

(Print Regional Council Chairman's Name) (Regional Council Chairman's Signature) (Date)

(Print Regional Medical Director's Name) (Regional Medical Director's Signature) (Date)

(Print Regional Coordinator's Name) (Regional Coordinator's Signature) (Date)

(Print State EMS License Officer's Name) (State EMS License Officer's Signature) (Date)