ANNUAL AED PROGRAM DATA REPORT
JANUARY 1, _____ TO DECEMBER 31, _____

Service Provider

Address | City | Zip Code

AED Program Coordinator

Phone# | Fax#

DATE	INCIDENT NUMBER	WAS CARDIAC ARREST WITNESSED?	WAS CPR IN PROGRESS PRIOR TO ARRIVAL?	WAS INITIAL CARDIAC RHYTHM V-FIB OR V-TACH?	NUMBER OF SHOCKS DELIVERED	DID PULSE RETRUN AFTER DEFIBRILLATION?	PATIENT TRANSPORT DESTINATION	EMS AGENCY USE ONLY WAS PATIENT DISCHARGED FROM HOSPITAL?

Please document the requested information on all patients that meet the San Luis Obispo County criteria for application of the AED as the incidents occur throughout the year.