Print Form

Mountain-Valley
Emergency Medical Services Agency

Notification of Use
of
Automatic External Defibrillator

Company Name:	
Date of Use:	Time of Use:
Patient's Name:	
Shock Administered: Yes ____ No ____	
Ambulance Provider to whom care was transferred:	
AED Operator:	
This form must be submitted within 24 of AED use. Send or fax to: Mountain-Valley EMS Agency 1101 Standiford Avenue, Suite D-1 Modesto, CA 95350 att: Health Club AED (fax) 209-529-1496	