SIERRA-SACRAMENTO VALLEY EMS AGENCY
ANNUAL AED FIELD REPORT FORM

REFERENCE NO. 474-C

JANUARY 1, _____ - DECEMBER 31, _____

_____ _____ _____

(AED Service Provider) (STATION) (ADDRESS)

_____

(CITY) (COUNTY) (CONTACT PERSON) (TELEPHONE NO.)

DATE	DISPATCH / INCIDENT NUMBER (OPTIONAL)	TIME OF PATIENT COLLAPSE	CARDIAC ARREST WITNESSED (YES/NO)	BYSTANDER CPR PERFORMED (YES/NO)	DID AED INDICATE "SHOCK ADVISED" (YES/NO)	TOTAL NUMBER OF SHOCKS DELIVERED	DID PULSE RETURN AFTER DEFIB. (YES/NO)

Please document the requested information on all patients that meet the S-SV criteria for application of the AED, as the incidents occur, throughout the year.