SIERRA-SACRAMENTO VALLEY EMS AGENCY
AED SERVICE PROVIDER APPLICATION

SERVICE PROVIDER	**CHIEF**
CONTACT PERSON	**AED INSTRUCTOR**
MAILING ADDRESS	
CITY	**ZIP CODE**
PHONE #	**FAX #**
E-MAIL ADDRESS	**BASE HOSPITAL**

Attach the following:

DESCRIPTION (For detailed description, see S-SV Policy Reference No. 475.)	***ENCLOSED***	***APPROVED (S-SV use only)***
a. **Letter of Intent** to provide AED service		
b. **Description of geographic area**		
c. **Proposed equipment location** and identification of vehicles		
d. **Training program** outline		
e. **Letter of support** from base hospital		
f. **Defibrillator information**		
g. **CQI program**		
h. **Policies and procedures** - AED orientation, AED competency, medical records, & data		
i. **Personnel Information**		

_____ _____

SIGNATURE OF APPLICANT **DATE**

Submit this application, with appropriate supporting documentation, to:

QI/Education Coordinator
S-SV EMS Agency
5995 Pacific Street
Rocklin, CA 95677

Phone (916) 625-1714
Fax # (916) 625-1730

S-SV EMS AGENCY USE ONLY							
Date rec'd	*Reviewed by*	*Date Approved*	*Letter sent*	*Personnel list*	*Contract signed*	*Orientation Completed*	*Provider #*