

**Notice of Intent to Provide
Public Access Defibrillation**

Original Notification Update

Entity Providing PAD

Name of Organization		() Telephone Number
Name of Primary Contact Person		E-Mail Address
Address		() Fax Number
City	State	Zip

Type of Entity (please check the appropriate boxes)

<input type="checkbox"/> Business	<input type="checkbox"/> Fire Department/District	<input type="checkbox"/> Private School
<input type="checkbox"/> Construction Company	<input type="checkbox"/> Police Department	<input type="checkbox"/> College/University
<input type="checkbox"/> Health Club/ Gym	<input type="checkbox"/> Local Municipal Government	<input type="checkbox"/> Physician's Office
<input type="checkbox"/> Recreational Facility	<input type="checkbox"/> County Government	<input type="checkbox"/> Dental Office or Clinic
<input type="checkbox"/> Industrial Setting	<input type="checkbox"/> State Government	<input type="checkbox"/> Adult Care Facility
<input type="checkbox"/> Retail Setting	<input type="checkbox"/> Public Utilities	<input type="checkbox"/> Mental Health Office or Clinic
<input type="checkbox"/> Transportation Hub	<input type="checkbox"/> Public School K - 6	<input type="checkbox"/> Other Medical Facility (specify)
<input type="checkbox"/> Restaurant	<input type="checkbox"/> Public School 6 - 12	<input type="checkbox"/> Other (specify)

PAD Training Program

<input type="checkbox"/> American Heart Association	<input type="checkbox"/> National Safety Council	<input type="checkbox"/> REMSCO of NYC, Inc
<input type="checkbox"/> American Red Cross	<input type="checkbox"/> Emergency Services Institute	<input type="checkbox"/> EMS Safety Service, Inc
<input type="checkbox"/> American Safety & Health Institute	<input type="checkbox"/> Medic First Aid International	<input type="checkbox"/> State University of NY

Automated External Defibrillator

Manufacturer of AED Unit	Model of AED Pediatric Capable <input type="checkbox"/>	Number of Trained PAD Providers	Number of AEDs
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Emergency Health Care Provider

Name of Emergency Health Care Provider (Hospital or Physician)	Telephone Number
Address	() Fax Number
City	State
	Zip

Name of Ambulance Service and 911 Dispatch Center

Name of Ambulance Service and Contact Person	Telephone Number
Name of 911 Dispatch Center and Contact Person	County

Authorization Names and Signatures

CEO or Designee (Please print)	Signature	Date
Physician or Hospital Representative (Please print)	Signature	Date

Public Access Defibrillation

Collaborative Agreement Between

And

_____ has chosen to provide Public Access Defibrillation (PAD) to their community. As a provider of Public Access Defibrillation (PAD), _____ has chosen _____ as their Emergency Health Care Provider. In satisfaction of the requirements for the provisions of Public Access Defibrillation (PAD), this agreement is being shared with the North Country Regional Emergency Medical Services Council.

Training Requirements

The PAD providers shall ensure that all persons designated to operate an AED successfully complete an AED training course which has been approved by the New York State Department of Health or the New York State Emergency Medical Services Council. Subsequent retraining according to American Heart Association (AHA) standards will be completed every two years. This retraining will reflect any changes in policy and/or procedure as recommended by the AHA or any other approved provider of AED training. As well, all personnel will attend a yearly in-service on the use of the unit.

Immediate Calling of 911

All _____ personnel that use the AED unit will contact 911 and ensure that an ambulance is dispatched to the proper location.

Location of AED unit

The Automated External Defibrillator (AED) used by _____ is a _____ and is currently in date and meets all requirements of local and state authorities. The unit will be stored in the primary response vehicle(s)/ area (location of AED).

Maintenance and Checkout procedures

A monthly checklist should be completed by personnel following the manufacturer's guidelines for checking the AEDs for readiness and will check for contents of the AED unit to ensure it contains at the minimum:

- One CPR pocket mask
- One set of defibrillation pads
- One disposable razor
- One data collection sheet
- Two pairs of disposable gloves
- One hand towel
- One pair of scissors
- Sign on Entrance of building that states where the defibrillator is located

Documentation Requirements

In the instance of usage of the AED, the original copy of the attached data collection sheet will be kept on file with the organization and a copy will be forwarded to the Regional EMS Council at the North Country Program Agency at the address below.

The Emergency Health Care Provider should be notified within 24 hours of the use of the AED and should also be forwarded a copy of the data collection sheet to review each usage.

If the Emergency Health Care Provider changes, a new Collaborative Agreement and NYS DOH Form 4135 (Notice of Intent to provide Public Access Defibrillation) shall be filed within five (5) business days. Additionally, if the emergency Health Care Provider resigns, s/he shall immediately notify the Regional EMS Council in writing and provide a new updated Collaborative Agreement, along with NYSDOH form 4135 to the North Country Regional Emergency Medical Services Council at the following address:

North Country EMS Program Agency
34 Cornell Drive, WH 027
Canton, New York 13617

Quality Improvement Activities

As requested by the Regional EMS Council, _____ will participate in activities necessary to improve the quality of care delivered relative to Automated External Defibrillation (AED).

The above are the procedures which will be followed in regards to providing Public Access Defibrillation (PAD) to the _____ agrees to be a provider of Public Access Defibrillation (PAD) in collaboration with _____

Signed,

CEO/President of organization Date

Emergency Health Care Provider Date



North Country EMS Program Agency

“Serving Jefferson, Lewis & St. Lawrence Counties”

Ann M. Smith, EMT-CC, Director

Mysti L. Mattice, Secretary

Public Access Defibrillation Data Collection Form

Name of organization: _____

Date of incident: ___/___/___

Time of incident: ___:___ am/pm

Patient's age: ____

Patient's sex: () Male () Female

CPR prior to defibrillation: () Attempted () Not Attempted

CPR started by: () Bystander () Staff () Nurse () EMT

Estimated time (in minutes) from collapse to AED application: _____

Number of shocks given: ____ () No shock given

Transporting ambulance: _____

Hospital patient was transported to: _____

Patient outcome to the best of your knowledge:

() Remained unresponsive

() Became responsive

() Spontaneous return of pulse

() Spontaneous return of pulse and respiration

() Dead on arrival in Emergency Dept.

() Died in Emergency Dept.

() Died within 24 hrs. of admission

() Died more than 24 hrs. after admission

() Discharged alive