



Los Angeles County EMS Agency
 Attn: AED Program Coordinator
 10100 Pioneer Blvd, Suite 200
 Santa Fe Springs, CA 90670
 Tel: (562) 347-1500 Fax: (562) 941-5835

PAD Post Event Report

After each use of the AED, by law you must send a report to the EMS Agency. Complete as much information as possible and submit by mail or fax within 72 hours

Date of Incident:	Time of Incident:	Team/Shift/Unit:	Name of person who applied AED:
Time 911 called:	Time 911 arrived:	Name of 911 Agency:	<input type="checkbox"/> Fire Dept <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Other
Victim's Name:	Date of Birth:	Age:	Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
Victim's Address:			
Location of Incident: Home <input type="checkbox"/> Work <input type="checkbox"/> Public Place <input type="checkbox"/> Healthcare Facility <input type="checkbox"/> Other <input type="checkbox"/> _____ Address of incident: _____			
Witnessed Arrest (seen or heard)? Yes <input type="checkbox"/> No <input type="checkbox"/> Witnessed by Whom: _____ Approximate "down" time: _____			
Signs of Injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain: _____			
Bystander CPR administered? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, Name(s): _____			
Position victim was found in (i.e. lying, sitting): _____			
Total number of shocks delivered: _____ Did victim regain a pulse? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Name of 911 Agency who took over care of victim: _____ Time: _____			
Equipment failure / problems? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, explain: _____			
Completed by: _____ Title: _____ Date: _____ Contact #: _____ Report sent to EMS Agency: Yes <input type="checkbox"/> No <input type="checkbox"/>			