Automated Defibrillation Notification
Vermont Department of Health

Name of Organization: _____

Mailing Address: _____

City/State/Zip: _____

Contact Person Name: _____

Contact Person Telephone: _____

Contact Person E-mail: _____

Brand of Automated Defibrillator(s) Purchased: _____

Number of Automated Defibrillator(s) Purchased: _____

Specific location of the Automated Defibrillator(s): _____

_____

_____

Date the defibrillator was placed in operation: _____

VT statute also requires notification of the ambulance or first responder service providing emergency coverage to your location. A copy of this form may be sent to them. If you are not certain about which agency provides coverage to your location, please contact us for assistance.

As the contact person for this organization, we will maintain the automated defibrillator(s) under our control in accordance with the applicable standards of the manufacturer and will notify emergency medical services responders through the 9-1-1 system whenever an automated defibrillator is used:

_____ _____

Signed Date

Return this form to: Vermont Department of Health
EMS Office
Box 70, 108 Cherry St.
Burlington, VT 05402

800-244-0911 or 802-863-7310 fax: 802-863-7577 www.state.vt.us/health/ems