



Community Public Access Defibrillator (PAD)

Registry: Site Documentation Form

<input type="checkbox"/>	Request Medical oversight of AED Program <i>I currently have an Automated External Defibrillator and would like to obtain medical oversight.</i>	
<input type="checkbox"/>	Request Registration of an Automated External Defibrillator (AED) <i>I currently have an Automated External Defibrillator and medical oversight and would like to register the device.</i>	
	Medical Director: _____	Program Name: _____
<input type="checkbox"/>	Request to update information <i>My device is registered with EMS and I would like to update my site information.</i>	

Customer Information: Please PRINT LEGIBLY

****Required Information**

**Company or; _____ <i>If Private Resident list</i>	
**Customer Name: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> First Name Last Name </div>	
Business Type: <i>(Ex: Law offices, School, Manufacturer, Public pool)</i> _____	
**Physical Address: _____	
Address 1:	_____
	<i>Street Address</i>
	<i>Suite/Apt #</i>
Address 2:	_____
	<i>Street Address</i>
	<i>Suite/Apt #</i>
City, State, Zip:	_____
	<i>City State Zip</i>
**Mailing Address: <input type="checkbox"/> <i>Same as Physical Address</i>	
Address 1:	_____
	<i>Street Address</i>
	<i>Suite/Apt #</i>
Address 2:	_____
	<i>Street Address</i>
	<i>Suite/Apt #</i>
City, State, Zip:	_____
	<i>City State Zip</i>
Days of Operation:	<input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun <input type="checkbox"/>
	<i>Please check all that apply 7days/Week</i>
Hours of Operation:	_____ <input type="checkbox"/> 24/7 <i>(Ex: Private Residence, 24hr Business)</i>
	<i>Start Time End Time</i>

**1st Contact: <i>List your Site Coordinator</i> Name _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> First Last </div> Title _____ Phone _____ Cell _____ Email _____	**2nd Contact: <i>List the Site Manager</i> Name _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 20px;"> First Last </div> Title _____ Phone _____ Cell _____ Email _____
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Training Information:

Training Program: <i>Ex: American Heart Association, American Red Cross</i>	
Number of People trained: _____	Date initial Training completed: _____

**Total Number of AED's: _____ <i>If you have more than one device please copy this page to list each device individually to record a complete list of your devices.</i>	
AED # _____	Serial # _____ Date AED put into operation _____
**Make _____ **Model _____	
Location of the Device: <i>Same as</i> <input type="checkbox"/> <i>Physical Address</i>	
Address 1: _____ <div style="text-align: right; margin-right: 100px;"><i>Street Address</i></div> <div style="text-align: right;"><i>Suite/Apt #</i></div>	
Address 2: _____ <div style="text-align: right; margin-right: 100px;"><i>Street Address</i></div> <div style="text-align: right;"><i>Suite/Apt #</i></div>	
City, State, Zip: _____ <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <i>City</i> <i>State</i> <i>Zip</i> </div>	
Number of Employees at this location _____	Number of Visitors _____ <i>Private Residence: List number of people who reside at this location</i> _____
Placement of the Device: <i>Describe the approximate location your device is placed in your home, business or vehicle:</i>	
FOR EMS USE ONLY:	
Site Visit Completed by: _____ <div style="display: flex; justify-content: space-between; width: 100%; font-size: small;"> <i>First Name</i> <i>Last Name</i> <i>Agency</i> </div>	
Date of Site Visit: _____	Local Fire Dept: <i>List the name of the Fire Dept that responds to your location.</i>

Return completed forms to:

1. Any EMS Team Member
2. Via Email to Titus.EMS@titusregional.com
3. Via Fax to 903-572-0031

Online forms can be saved and emailed or printed and returned via fax.