EMMCO West, Inc.
AED PROGRAM APPLICATION

Name/Address

Name of Organization _____ Affiliate # (If applicable) _____

Box _____ Street Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____ E-mail _____

Type of Organization

- ☐ Ambulance Service
- ☐ Business/Industry
- ☐ Fire Service
- ☐ Police Department
- ☐ QRS
- ☐ Rescue
- ☐ Security Agency
- ☐ Other

Medical Director (** Medical Director must be Board Certified in Emergency Medicine or ACLS Provider)*

_____ ☐ M.D. ☐ D.O.
Name of Medical Director

Box _____ Street Address _____

City _____ State _____ Zip _____

- ☐ Yes ☐ No Licensed M.D/D.O. (*attach copy*)
- ☐ Yes ☐ No Current ACLS Card (*attach copy*)
- ☐ Yes ☐ No Board Certification in Emergency Medicine (*attach copy*)

AED Program Coordinator

Name of AED Coordinator _____ Certification # _____ Level _____

Box _____ Street Address _____

City _____ State _____ Zip _____

Telephone _____

- ☐ Yes ☐ No AED Provider
- ☐ Yes ☐ No Approved by Medical Director
- ☐ Yes ☐ No Approved by Service/Company

1. If your organization is not a licensed EMS service, please provide a brief description of how it will coordinate efforts with the EMS System:

_____

_____

_____

_____

_____

_____

_____

_____

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_____

2. If your organization is a licensed BLS ambulance service or a QRS organization, with what ALS providers is there a response agreement? (Note: *QRS - also indicate the BLS ambulance services for which you respond.) (Attach copies of the agreements.)

ALS Ambulance Services	BLS Ambulance Services
_____	_____
_____	_____
_____	_____

Please Attach:

- ☐ AED Personnel Roster
- ☐ Copies of Certifications as requested in the Application
- ☐ Skill maintenance requirements as identified by the AED Medical Director
- ☐ Quality Assurance Plan
- ☐ Service Plan for public Education and information in the proposed service area

AGREEMENT

This completed "AED Service Application" has been read in its entirety and all information contained herein, or submitted separately in support of the application is accurate and complete.

The undersigned agree that the service will adhere to all guidelines and position responsibilities as defined by the EMMCO West Regional AED program. We further agree to notify EMMCO West, Inc. within seven (7) calendar days of any change in status that affects the capability of the service to comply with the AED Program requirements:

_____	_____	_____
Signature, Ambulance President/CEO	*Print,* Ambulance Service President	Date
_____	_____	_____
Signature, Amb Chief Operations Officer	*Print,* Ambulance Service Chief	Date
_____	_____	_____
Signature, Service AED Medical Director	*Print,* Service AED Medical Director	Date
_____	_____	_____
Signature, Service AED Program Coordinator	*Print,* Service AED Program Coordinator	Date

Regional Use Only

_____	_____
Approval Signature	Approval Date
_____	_____
Service Notification	DOH Notification

Rev. 3/99