Automatic External Defibrillator
Operations Plan For:

Facility____

Address/Street Address____
____

Program Contact Person:________________________________Phone______________

Alternate Contact Person________________________________Phone______________

Actual location of the AED within the Facility:__________________________________
____

How will the staff access the AED from its primary location when it is needed for use or regular maintenance checks?____
____
____

Hours of operation that the AED will be available for use:________________________
____

Will this AED be available for use off site? Yes__________ No__________

Manufacturer of AED:____

Model Number:____

Serial Number:____

Physician Program Director:____
Address:____
Phone:__________________________Fax:____________________________________

How is the use of the AED coordinated with the local EMS system?: The information contained in this AED Operations Plan will be submitted to the primary emergency medical services provider as stipulated in the rules and regulations of the Tennessee Department of Health, Division of Emergency Medical Services 1200-12-1-.19.

The staff of this facility has been trained in the use of an AED under the guidelines of this approved training program:____
____

(Refer to the list of approved training programs in the Tennessee Department of Health, Division of Emergency Medical Services rules and regulations 1200-12-1-.19)

****Attach to this Operations Plan a list of those staff in your facility that have been trained in the use of an AED.**

Describe your facilities plan of action for the proper use of the AED:
____
____
____
____
____

Once the primary emergency medical services provider has reviewed this plan to see that the requirements contained in 1200-12-1-.19 are complete, by agreement with the local emergency communications district, they will forward to them the information required for entry into the computer aided dispatch system for dissemination to local emergency responders when necessary.

Attach to this Operations Plan the maintenance and testing procedures necessary to maintain the AED. (Sample forms included. Use if you so choose and submit as documents intended for use. If you choose not to use these forms, submit those that you intend to use.)

Attach to this Operations Plan the form you will submit to the local primary emergency medical service provider and your physician program director when the AED has been used. (Sample forms included. Use if you so choose and submit as documents intended for use. If you choose not to use these forms, submit those that you intend to use.)

This information will be submitted to:

Washington County – Johnson City EMS
Major Steve Croley – Operations Director
507 E. Main St.
Johnson City, TN 37601
423-975-5504

AED Placement Authorization

Facility____

Mailing Address____

Street Address____

Contact Person___________________________________Phone__________________

Alternate Contact Person__________________________Phone__________________

Authorizing Physician____

Signature of Physician____

Address of Authorizing Physician____

Phone__________________________Fax____________________________________

Emergency Medical Services Approval:

Name__________________________________

Address________________________________

____

Phone__________________________________

Signature_______________________________

Once this form has been signed by EMS a copy will be mailed to the contact person listed to be kept with the AED Operations Plan.

AED Response Log

*To be submitted to EMS and the Physician program director each time the AED is used

Date	______________________________________	
Incident Location	______________________________________	
Witnessed Cardiac Arrest	Y	N
Bystander CPR	Y	N
Time Facility Notified of Emergency	______________________________________	
Time EMS Notified of Emergency	______________________________________	
Time EMS Notified of AED Use	______________________________________	
Patient Breathing When Encountered	Y	N
Pulse Present When Encountered	Y	N
Pulseless After First Encountered	Y	N
Time CPR Started	______________________________________	
Time of First AED Shock	______________________________________	
Number of AED Shocks	______________________________________	
Time EMS Arrived	______________________________________	

AED Response Log and AED Data Sent To

EMS	Y	N
Physician	Y	N

Responders

__________________________ __________________________

__________________________ __________________________

Patient Information:
Name_____________________________________Age___________M___F___

AED Monthly Checklist

Model___________________________________Serial Number________________

Unit Location____

Date	_____	_____	_____	_____	_____
Clean, no sign of damage	_____	_____	_____	_____	_____
Supplies: 2 sets pads undamaged and within expiration date	_____	_____	_____	_____	_____
scissors, razor, pocket mask, gloves (hand towel)	_____	_____	_____	_____	_____
spare battery pack within expiration date	_____	_____	_____	_____	_____
status indicator light ok passed self test	_____	_____	_____	_____	_____
Inspected by: Initials of operator Completing inspection	_____	_____	_____	_____	_____

Remarks, Deficiencies, Corrective Action_____________________________________
____
____
____
____
____
____
____

Battery Expiration Date:___________________________

Previous Use of This AED Y N