

AED Placement Notification Form

(as required by K.S.A. 65-6149a(b))

The **Emergency Medical Service** which operates in the geographic area of the location of the automated external defibrillator.

Name: _____

Address: _____

Phone: _____

Fax: _____

Local EMS Director (or designee)

_____ (Please Print)

Person or entities acquiring an automatic external defibrillator

Name: _____

Address: _____

Phone: _____

Fax: _____

Name of Prescribing Physician (If applicable)

(as described in K.S.A. 65-6149a(a)(3))

_____ (Please Print)

Location of AED Placement:

Model & Serial Number of AED:

Expected date of placement of AED:

Date Notified of AED Placement:

Initial CPR/AED Training Date:

Number of trained individuals:

Person placing the AED:

_____ (Please Print)

Management of AEDs (Optional)

Name of Local dispatch agency:

Frequency of maintenance/Inspection:

Responsible person/department:

Please complete a form for each AED being placed.

Landon State Office Building, Room 1031

900 SW Jackson Street

Topeka, Kansas, 66612-1228

This form is provided by the Kansas Board of Emergency Medical Services