

Original Notification Update

Entity Providing PAD

Name of Organization	Agency Code	() Telephone Number
Name of Primary Contact Person		E-Mail Address
Address		() Fax Number
City	State	Zip

Type of Entity (please check the appropriate boxes)

<input type="checkbox"/>	Ambulance	<input type="checkbox"/>	Restaurant	<input type="checkbox"/>	Private School
<input type="checkbox"/>	Business	<input type="checkbox"/>	Fire Department/District	<input type="checkbox"/>	College/University
<input type="checkbox"/>	Construction Company	<input type="checkbox"/>	Police Department	<input type="checkbox"/>	Physician's Office
<input type="checkbox"/>	Health Club/Gym	<input type="checkbox"/>	Local Municipal Government	<input type="checkbox"/>	Dental Office or Clinic
<input type="checkbox"/>	Recreational Facility	<input type="checkbox"/>	County Government	<input type="checkbox"/>	Adult Care Facility
<input type="checkbox"/>	Industrial Setting	<input type="checkbox"/>	State Government	<input type="checkbox"/>	Mental Health Office or Clinic
<input type="checkbox"/>	Retail Setting	<input type="checkbox"/>	Public Utilities	<input type="checkbox"/>	Other Medical Facility (specify)
<input type="checkbox"/>	Transportation Hub	<input type="checkbox"/>	Public School K – 12	<input type="checkbox"/>	Other (specify)

PAD Training Program CPR AED training program must meet or exceed current ECC Standards.

--

Automated External Defibrillator

Manufacturer of AED Unit		Is the AED Pediatric Capable? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Trained PAD Providers	Number of AEDs
--------------------------	--	--	---------------------------------	----------------

Emergency Health Care Provider

Name of Emergency Health Care Provider (Hospital or Physician)	Physician NYS License Number	() Telephone Number
Address		() Fax Number
City	State	Zip

Name of Ambulance Service and 911 Dispatch Center

Name of Ambulance Service and Contact Person	() Telephone Number
Name of 911 Dispatch Center and Contact Person	County

Authorization Names and Signatures

CEO or Designee (Please print)	Signature	Date
Physician or Hospital Representative (Please print)	Signature	Date