Nassau Regional Medical Advisory Committee

131 Mineola Blvd. Suite 105, Mineola, NY 11501
Phone: (516) 542-0025 - Fax: (516) 542-0049

Application for AED Use

1. Agency Name _____

2. Address _____

3. Type of Dispatch: ☐ Firecom ☐ Local P.D. ☐ Own Dispatcher
   ☐ Other _____

4. Service Type:

   ☐ Certified Ambulance
   ☐ BLS First Response Agency (no ambulance)

4 A. For BLS first responder list the agencies that transport from your district:

_____ _____
(*attach a copy of mutual aid agreements from each agency*)

5. Number of Certified Personnel at Each Level:

   _____CFR _____EMT _____EMT-CC _____EMT-P

6. Agency Medical Director (MD or DO)_____(must complete attachment)

7. Brand and Model of AED(s) _____

8. Please attach a copy of your agencies Quality Assurance program (mandatory for AED certification)

9. Other medical supplies on vehicle (if unit is not on an ambulance):
   ☐ Jump Bag ☐ BVM ☐ Other _____

10. Contact Person: Name_____ Title_____

    Day Time Phone #_____

Signature of Agency Chief _____ **Date** _____

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Medical Director Statement for AED Certification

I _____ am the Medical Director for the
(Print Name)
_____. I am a licensed physician/surgeon in
(Print name of EMS Agency)

the State of New York and Specialize in _____. I understand that my agency is applying for authorization to use a Semi-Automatic External Defibrillator, and if approved, I will aid in the Quality Assurance program required for use of such a device.

_____ _____ _____
Medical Director Signature License # Date

Please attach a copy of License or State Registration