New York State Department of Health

Bureau of Emergency Medical Services

Notice of Intent to Provide Public Access Defibrillation

Original Notification ☐ Update ☐

Entity Providing PAD

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

Type of Entity (please check the appropriate boxes)

	Business		Fire Department/District		Private School
	Construction Company		Police Department		College/University
	Health Club/ Gym		Local Municipal Government		Physician's Office
	Recreational Facility		County Government		Dental Office or Clinic
	Industrial Setting		State Government		Adult Care Facility
	Retail Setting		Public Utilities		Mental Health Office or Clinic
	Transportation Hub		Public School K – 6		Other Medical Facility (specify)
	Restaurant		Public School 6 - 12		Other (specify)

PAD Training Program (Indicate the training program chosen. Only the approved programs may be used. Please see Policy Statement 09-03 [http://www.health.state.ny.us/nysdoh/ems/policy/09-03.htm])

Automated External Defibrillator

Manufacturer of AED Unit	Model of AED Pediatric Capable	Is the AED Pediatric Capable? ☐ Yes ☐ No	Number of Trained PAD Providers	Number of AEDs

Emergency Health Care Provider

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

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

DOH-4135(4/09) ***Complete this form and send it with your completed Collaborative Agreement to the REMSCO for you area***