

APPLICATION FOR RURAL AUTOMATED EXTERNAL DEFIBRILLATION GRANT

(Print or Type All Information)

NAME/ADDRESS:

1. _____ 2. _____
Name of Organization *Name of Contact Person*

_____ _____
Street Address *P.O. Box /Suite/Apartment Number*

_____ - _____ - _____
City *State* *Zip Code* *Telephone*

_____ - _____
E Mail Address *Fax*

3. YES NO Are you affiliated with a local Community Health Improvement Partnership (CHIP)
 If yes, please complete #4.

4. _____ _____
Name of CHIP *Name of Contact Person*

_____ _____
Street Address *P.O. Box /Suite/Apartment Number*

_____ - _____ - _____
City *State* *Zip Code* *Telephone*

_____ - _____
E Mail Address *Fax*

5. **TYPE OF ORGANIZATIONS IN PARTNERSHIP:**

- | | | |
|--|--|--|
| <input type="checkbox"/> Ambulance Service | <input type="checkbox"/> Police Department | <input type="checkbox"/> Security Agency |
| <input type="checkbox"/> Business/Industry | <input type="checkbox"/> QRS | <input type="checkbox"/> Public Access |
| <input type="checkbox"/> Fire Service | <input type="checkbox"/> Rescue | <input type="checkbox"/> Other: _____ |

6. **NAMES OF ORGANIZATIONS INVOLVED IN PARTNERSHIP:**

7. **MEDICAL ADVISOR (REQUIRED FOR EMS)**

Name of Prescribing/Advisory Physician

_____ _____
Street Address *P.O. Box /Suite/Apartment Number*

_____ - _____ - _____
City *State* *Zip Code* *Telephone*

_____ - _____
E-mail Address *Fax*

8. AED PROGRAM COORDINATOR

Name of AED Coordinator

Street Address *P.O. Box /Suite/Apartment Number*

City *State* *Zip Code* *Telephone*

E Mail Address *Fax*

9.

If your organization is not a recognized QRS or a licensed EMS service, please provide a brief description of how your organization will coordinate efforts with the EMS System and the local 911 center.

Please attach: A copy of prescription to obtain device.
 Signed letter of commitment
 Provide a copy of proposed Quality Assurance plan including a plan for reporting all AED uses to the regional EMS council. (Public access only)
 Provide a maintenance plan for the device.
 Provide a copy of plan for how the AED would be used to respond to cardiac emergencies.

10.

I have reviewed this application and all of the information contained herein, or submitted separately in support of the application is accurate and complete.

Signature of Organization Representative *Date*

11. (Required for EMS)

I do hereby acknowledge and accept the role of providing medical advice and direction and am in support of this AED application. I have reviewed attached quality assurance plan and concur with its contents.

Signature of Physician *Date*

12.

I do hereby acknowledge and accept the position as the AED Program Coordinator and am in support of this AED application. I have reviewed the attached requirements and agree to maintain the standards required.

Signature of AED Program Coordinator *Date*

13.

Name of Individual Completing the Application *Title*

Telephone *E Mail Address*

14.

REGIONAL EMS COUNCIL USE ONLY:

I HAVE REVIEWED THE ATTACHED APPLICATION AND INFORMATION PROVIDED AND RECOMMEND FUNDING TO THIS PARTNERSHIP.

SIGNATURE _____ TITLE _____

Printed Name _____ **Date:** _____ **Region:** _____