

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	() Fax Number
City	State Zip

Type of Entity (please check the appropriate boxes)

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

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Automated External Defibrillator

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

Name of Emergency Health Care Provider (Hospital or Physician)	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

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