



Westchester Regional EMS Council

PAD Location Form

Please type or print legibly.

Date: _____

Name of entity providing PAD: _____

Mailing address _____

City _____ State _____ Zip _____ Phone () _____

Main Contact Name _____ Email _____

Main Contact Phone () _____ Fax () _____

LOCATION OF AEDS:

Please identify the location of each AED unit in the spaces below.

1	Street Address:	Bldg/Floor/Room/Suite:
	City, State and ZIP:	Department name (if applicable):
	Contact Person at location:	Location Contact Telephone:
2	Street Address:	Bldg/Floor/Room/Suite:
	City, State and ZIP:	Department name (if applicable):
	Contact Person at location:	Location Contact Telephone:
3	Street Address:	Bldg/Floor/Room/Suite:
	City, State and ZIP:	Department name (if applicable):
	Contact Person at location:	Location Contact Telephone:
4	Street Address:	Bldg/Floor/Room/Suite:
	City, State and ZIP:	Department name (if applicable):
	Contact Person at location:	Location Contact Telephone:

**Please make additional copies of this form as necessary.
Attach all location forms to NYS DOH 4135 – Notice of Intent to Provide Public Access Defibrillation.**