

WINCHESTER PUBLIC SCHOOLS
WINSTED, CONNECTICUT

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICE
860-509-7975

REGISTRY # _____
PSAP # _____

AUTOMATIC EXTERNAL DEFIBRILLATOR (AED)

REGISTRY FORM

(REQUIRED BY PUBLIC ACT 98-62 - PLEASE PRINT OR TYPE - USE ONE FORM PER AED)

NAME OF OWNER: _____

MAILING ADDRESS: _____

NAME OF CONTACT PERSON: _____

TELEPHONE #: _____ FAX #: _____

AED MANUFACTURER: _____

MODEL: _____ SERIAL #: _____

NAME OF PRESCRIBING PHYSICIAN: _____

IF AED IS SITUATED AT A FIXED LOCATION, PLEASE INCLUDE TOWN, STREET ADDRESS,
BUILDING NAME OR NUMBER, AND FLOOR LOCATION. NOTE: BE AS SPECIFIC AS
POSSIBLE: _____

IF AED WILL NOT BE IN A FIXED LOCATION, PLEASE DESCRIBE HOW AND WHERE IT WILL
BE DEPLOYED: _____

COMPLETED FORM SUBMITTED VIA MAIL TO: STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OEMS - AED REGISTRY
410 CAPITOL AVENUE MS #12-EMS
P. O. Box 340308
HARTFORD, CT 06134-0308

SUBMITTED BY: _____ DATE: _____