EVENT SUMMARY FORM

Mail or fax copy to your medical director and
mail or fax a copy to
Riverside County EMS Agency at
4065 County Circle Drive, Suite 208
Riverside, CA 92503
Office (909) 358-5029 Fax (909) 358-5160

Location (address) of event:
____

Date of event:____

Time of event:____

Name and number of AED Medical Director:
____

Name of AED Program
Coordinator:____

Was the collapse witnessed non-witnessed ?

Names of
rescuers:____

____

Was the internal response plan activated? Yes No

Was 9-1-1 called? Yes No

Was CPR given before the AED arrived? Yes No

If yes, name of rescuer(s):
____

Were shocks given? Yes No If yes, how many?_____ Unknown

Did the victim...regain a pulse? Yes No

Resume breathing? Yes No

Regain consciousness? Yes No

Was the victim transported to a hospital? Yes No

If known, which
hospital?____

Any problems
encountered?____

____

Name and number of person completing form:
____

____

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Supplemental Information Sheet:

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