OFFICE OF EMERGENCY SERVICES
SAN BENITO COUNTY
EMERGENCY MEDICAL SERVICES DIVISION

Form: 911

PUBLIC ACCESS DEFIBRILLATION
POST-INCIDENT REPORTING

Name of person completing form:	Date:
Department/Building:	Street Address:
Location/Address of service	Responding Ambulance Unit #
Patient Name (if known):	Patient Date of Birth (if known):

CPR INFORMATION

CPR Performed? ☒ Yes ☐ No	Type of CPR performed: ☐ Compressions Only ☐ Compressions and Ventilations
Type of Ventilation performed: ☐ Mouth-to-Mouth ☐ Mouth-to-Mask	
Name of person(s) providing CPR:	
Did the AED instruct you to defibrillate (shock) the patient: ☐ Yes ☐ No	
What was the total number of defibrillations (shocks) delivered?	
Did patient regain consciousness: ☐ Yes ☐ No	

TIMELINE

Witnessed Cardiac Arrest	Time:
Start of CPR	Time:
First Defibrillation Given	Time:
Arrival of First Responders to Scene	Time:

ANYTHING YOU'D LIKE TO ADD:

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Within 24 hours of AED use or attempted use, please email the completed form to the San Benito County EMS Agency at kmangano@cosb.us.

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