

Victim Information

Last Name _____		First Name _____	
Age or DOB _____	Gender: M F (circle one)		Status: Employee Visitor (circle one)
Special Conditions: (circle one if any)			
Pace Maker	Wet Torso	Other: _____	
Hairy Chest Medicine Patch			
Medical symptoms observed or described by victim: _____			

Emergency Event Information

Date _____	Exact Location (i.e. 1-2-B23) _____
Conditions influencing safety and security at scene of emergency: _____	
Name of witnesses to the collapse (if any): _____	
Attach any witness statements	

Status of Victim

Initial status of victim: _____	
Condition of victim upon departure: _____	
Hospital Information	
Name of hospital: _____	
Date Received: _____	Time Received: _____

Response Timeline

Time victim found _____	Time 9-911 called _____	Time AED team member arrived _____	Time of AED arrival _____
Time of first shock _____	Time of EMS arrival _____	Time of EMS departure _____	

Response Evaluation

Who found the victim: _____
Who notified receptionist: _____
Who notified AED team members: _____
Who called 9-911: _____
Who delivered the AED: _____
Who escorted EMS team to the Victim: _____

AED Team Response Evaluation

North Carolina Department of Health and Human Services
 Division of Public Health
 Post AED Event Evaluation

Which AED team members Responded to the Emergency: _____			
Which team member arrived first: _____			
Who assessed the victim: _____			
AED team member	YES	NO	
Was this person trained	YES	NO	Date last Trained: _____
If any Special Conditions, what steps were taken: _____			
Who maintained crowd control and other safety issues: _____			
Steps taken: _____			
Was CPR administered:	YES	NO	By Whom: _____
Was AED administered:	YES	NO	By Whom: _____
Number of shocks delivered to victim: _____			
Victims response to CPR and AED treatment: _____			

Strategies for Improvement:

Were ALL steps followed during the response to the emergency event:	YES	NO
Which steps were missed (if any):		
What improvements could be made:		
Plan of action:		

 Dr. Jeffrey Engel
 Medical Advisor Name

 Signature

 Date

 Site AED Coordinator Name

 Signature

 Date

 DPH Safety Officer Name

 Signature

 Date