State Of Delaware
Office of Emergency Medical Services

Application for Automatic External Defibrillator Service Provider

Delaware Early Defibrillation Program

First State, First Shock! Program

Print Clearly and Answer All Sections Completely

Type (Check One):

❑ Initial Application (Requesting New AED) ❑ Change ❑ Registration Only (Privately Owned)

Agency Name:

Coordinator:

Phone:

Street Address:

Email:

City:

DE

Zip:

Fax:

Type of Service:

- ❑ EMS/Fire/Rescue
- ❑ Senior/Youth Center
- ❑ Healthcare
- ❑ Other (Please Describe)
- ❑ Law Enforcement/Corrections
- ❑ School/Higher Education
- ❑ Public Assembly
- ❑ Business/Industrial
- ❑ Government

Provide the following attachment (All entities except Fire/EMS/Law Enforcement):

1.) Statement from business or agency chief officer supporting program implementation.

Signature of Service Coordinator:

Date:

OEMS Use Only Below This Line

Received by OEMS (Initial/Date):

Reviewed By: (Initial/Date)

Status:

❑ Entered into Database ❑ Awaiting Additional Info ❑ Delivered

Date:

#:

Date:

Comments: