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

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 Date: #: ❑ Awaiting Additional Info ❑ Delivered Date:

Comments: