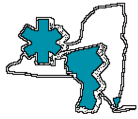

Westchester Regional EMS Council
PAD Location Form

Please type or print legibly.

Date:

Name of entity providing PAD:

Mailing address

City State Zip Phone ( )

Main Contact Name Email

Main Contact Phone ( ) Fax ( )

LOCATION OF AEDS:
Please identify the location of each AED unit in the spaces below.

1	Street Address:	Bldg/Floor/Room/Suite:
	City, State and ZIP:	Department name (if applicable):
	Contact Person at location:	Location Contact Telephone:
2	Street Address:	Bldg/Floor/Room/Suite:
	City, State and ZIP:	Department name (if applicable):
	Contact Person at location:	Location Contact Telephone:
3	Street Address:	Bldg/Floor/Room/Suite:
	City, State and ZIP:	Department name (if applicable):
	Contact Person at location:	Location Contact Telephone:
4	Street Address:	Bldg/Floor/Room/Suite:
	City, State and ZIP:	Department name (if applicable):
	Contact Person at location:	Location Contact Telephone:

Please make additional copies of this form as necessary.
Attach all location forms to NYS DOH 4135 – Notice of Intent to Provide Public Access Defibrillation.