AED Site Survey

Date: _____

Contacts: _____ Title: _____ Phone: _____
Email: _____ FAX: _____
_____ Title: _____ Phone: _____
Email: _____ FAX: _____
_____ Title: _____ Phone: _____
Email: _____ FAX: _____

Training Coordinator (If Different) _____ Title: _____ Phone: _____
Email: _____ FAX: _____

Monthly Inspections Performed by _____ Title: _____ Phone: _____
Email: _____ FAX: _____

Local EMS Company _____ Non-Emergency Phone: _____

Call 911 Special Prefix Required? ☐ If so, can it be altered? ☐

After calling 911, who in the company should be notified?

Name: _____ Title: _____ Phone: _____
Email: _____ FAX: _____

Name: _____ Title: _____ Phone: _____
Email: _____ FAX: _____

How will Responders be notified in event of an Emergency?

After Incident, who in the company should be notified?

Name: Title: Phone:
Email: FAX:
Name: Title: Phone:
Email: FAX:

Building Information

Square Footage Number of Floors Which Floors are Used by Company

Outdoor Work Areas?

Annexed Buildings?

Elevator? Yes No

If "Yes", does company have an Elevator "Lock-Down" procedure?

Yes No

Employee Information

Number of Employees	Employees with Heart Issues?	Working with High Voltage (240+) ?	Working in Isolated Areas?	Confined Spaces?
AM Shift				
PM Shift				
3rd Shift				

Employees with Issues

Employee Name	Issue	Location

On Site Medical

Is there a company nurse or medical/employee health department? ☐

Coverage Hours? _____

Employee Training

Training Requirement	Last Training Date	Number of Employees Trained
AED Training		
CPR Training		
First Aid Training		
Bloodborne Pathogen Training		
Emergency Oxygen Training		
OSHA Training		

Current Equipment	Equipment	Type	Location	Visible	Custodian Phone	First Aid or Responder Equipment	C*	Equip Xport Time **	Most Remote Location	Equipment Transport Time
	AED						*			
	Emerg. Oxygen									
	AED									
	Emerg. Oxygen									
	AED									
	Emerg. Oxygen									
	AED									
	Emerg. Oxygen									
	AED									
	Emerg. Oxygen									
	AED									
	Emerg. Oxygen									
	AED									
	Emerg. Oxygen									

* Critical Area Near This Location

** Equipment Transport Time to Critical Location

If there is an AED on-site, does the client have Medical Direction? _____ Yes _____ No

Notes and Recommendations:

(1)

(2)

(3)

(4)

(5)

(6)

(7)

(8)

(9)

(10)

(11)

(12)