BE A LIFESAVER HAWAI'I

Hilo Medical Center Foundation Automated External Defibrillator (AED) Application

Facility requesting AED: ____

Contact Person and Title: ____

Physical Address: ____

Mailing Address: ____

Phone: ______________________________ Cell Phone:_________________________

E-Mail: ___________________________________ Fax: ____________________

Reason for request:____

____

Describe unique needs i.e. at risk population, multi-use facility, etc.:_________________________

____

Do you currently have an AED at this location? ____ Yes ____ No

If you have an AED, please explain why an additional AED is requested: ______________________

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What is the number of people served? _________ Daily _________ Monthly _________ Annually

What age groups are served? ____

Will this facility accept responsibility for all AED maintenance such as replacement of defibrillator pads, batteries, and AED accessories? ______ Yes ______ No

Site for intended AED (site should be accessible during hours of operation): ____________________

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Name of person who will monitor the AED's readiness for use: ____________________________

Please mail completed application to:

Hilo Medical Center Foundation
1190 Waianuenue Avenue
Hilo, HI 96720

For Hilo Medical Center Foundation Use Only:

Date application received: ___________________________ *Date processed:* ____________________________________

Review Comments: ____

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Action Taken: ____