



**Department AED Protocol**

Instructions:

This form serves as the “written AED protocol” as identified in the UNCG AED program. This form must be completed by the Department AED Program Coordinator in conjunction with EHS prior to the installation of any AED.

Department: \_\_\_\_\_

Date Implemented: \_\_\_\_\_

**Section 1. Department AED Program Coordinator Contact Information:**

The AED Program Coordinator is the designee for submitting any AED Post Incident Usage Reports to EHS and Student Health Services, and must be trained in the use of AED’s.

Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Office Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Section 2 Technical Information**

\*This section will be completed by EHS once the units have been purchased.

Model(s) and Serial Number(s)

1. Manuf. /Model: \_\_\_\_\_ Serial Number: \_\_\_\_\_
2. Manuf. /Model: \_\_\_\_\_ Serial Number: \_\_\_\_\_
3. Manuf. /Model: \_\_\_\_\_ Serial Number: \_\_\_\_\_

## Section 4 Location

Location of the AED unit(s) within the building is at the discretion of the AED Coordinator with final approval by EHS. Consult with EHS staff prior to plan submission if assistance in determining location is desired. Guidelines to consider when determining AED location include: Located at or near:

- Main entrance/lobby/reception areas
- Near emergency phones/elevators/stair towers
- First aid/Security stations
- Main building corridors
- Areas of risk (i.e. gyms, public gathering spaces)

1. Building Name: \_\_\_\_\_

AED location (please be specific):  
\_\_\_\_\_

2. Building Name: \_\_\_\_\_

AED location (please be specific):  
\_\_\_\_\_

3. Building Name: \_\_\_\_\_

AED location (please be specific):  
\_\_\_\_\_

\*NOTE\* Attach a copy of the floor plan with the location marked. If you need assistance with getting a copy of your floor plan, EHS can provide this to you.

## Section 5 Training

Attach a current list of CPR/AED trained employees in the building.

A list of CPR/AED trained employees in the building must be maintained and updated regularly. Specify the employee name, job title, and date of latest training.

\*Training must be based on the guidelines of either The American Red Cross or The American Heart Association

Location where AED/CPR training records will be maintained:  
\_\_\_\_\_

Section 6 Maintenance Plan (Monthly Inspections)

Records must be maintained for the current and previous two years.

Maintenance plan is the responsibility of the AED Program Coordinator identified in this protocol. Monthly Inspections must be documented (EHS will provide log) and must include the following criteria:

- Date of the Inspection
- Inspector Name
- Is the unit intact and in good condition: Yes/No
- Is the battery functioning and present: Yes/No
- Are the AED Pads Present: Yes/No
- Are the AED Pads within their expiration period: Yes/No
- Comments if any of the above answers are “No”

\* Unit must be taken out of service if any of the inspection items are not correct.

Person responsible for the monthly inspection of the AEDs in this Work Unit Plan:

Name & Title: \_\_\_\_\_

Email: \_\_\_\_\_

Location where monthly inspection records will be stored for the AEDs in this Work Unit Plan:

\_\_\_\_\_

Section 7 Communication Plan for Out of Service Units

In the event that an AED is temporarily taken out of service, building occupants and others must be notified.

Follow these three steps when an AED is “Out of Service” and the location of the nearest “In Service” AED within the building (if applicable).

1. Ensure that the AED Departmental Program Coordinator for the AED is notified that the unit is out of service so that the necessary notifications can be made and replacement unit ordered.
2. A temporary “Out of Service” sign must be placed in the AED location. The sign should include a description of the nearest functioning AED in the building (if applicable), reminder to call 911 and the signature/date of the AED Work Unit Coordinator.
3. Notify EHS that the AED is unavailable.

Section 8 Signatures/Approval

This section must not be left blank.

Departmental AED Coordinator Name (Please Print): \_\_\_\_\_

Departmental AED Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

AED Program Administrator Name (Please Print): \_\_\_\_\_

AED Program Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_