APPLICATION FOR AED

Organization Name:

Contact Person:

Address:

Street or Mailing City State Zip

Phone:

Business Other Fax

E-mail: Website:

Is your organization a non-profit 501(c) 3? Yes No

What is the mission of your organization?

Who does your organization serve?

How many people are present in your facility or building on a weekly basis?

Describe your organization’s need for an AED.

Does your organization have any AEDs presently on-site?