

# Automated External Defibrillator Application

## Canadian Heartland

### For Office Use Only

Date received:		Application #:	
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### A. Applicant Information

Organization Name:		Application Date:	
Contact Person:		Title:	
Telephone:		Fax:	
Email:			
Address:			
Town:		Postal Code:	

### B. Facility Information

Building Name:					
Building Address:					
Type of facility:		Area served:			
Average daily use of facility	Average # of seniors:				
	Average # of adults:				
	Average # of children:				
Proposed location of new AED				# of AED units already in facility	
Will there be 24 hour access?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	If not, state operating hours:

### C. Justification

Why does your facility require an AED? (benefits)
How will your organization raise the matching funding for the remaining half of the costs, as well as future training and maintenance cost?
Who will maintain the AED? (clean, batteries, replacement items, etc.)

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### D. Approval

APPROVED <input type="checkbox"/>	NOT APPROVED <input type="checkbox"/>
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### E. Presentation

To be presented to:		Date:	
Location of Presentation:		Presenter:	