



Site Assessment Summary Report

Site Information

Site Name: _____

Contact Name: _____

Address: _____

City, State Zip: _____

Phone: _____

Fax: _____

E-Mail: _____

Date of Assessment: _____

Total number of AEDs recommended for this facility _____

Are there any locations within this facility not covered by the recommended number and placement of the AEDs? Y _____ N _____ If yes, describe _____

Specific recommendations for AED placements and style of cabinet (surface or semi-recessed):

1. _____

2. _____

3. _____

4. _____

5. _____

Submitted by:

Name: _____

Address: _____

City, State Zip: _____

Phone: _____

Fax: _____

E-Mail: _____