

Customer Prescription Order Form



Distributor: HeartSafe America

Faxed: _____

Site information				
Site Name: _____	Parent Site: _____			
Address: _____		City _____	State _____	Zip _____
		Street _____	County: _____	
Phone: _____				
2nd Phone: _____	Fax: _____			

Program Contact Person	
Name: _____	Title: _____
Email _____	
Direct Phone: _____	Fax: _____

AED Information	
Total Number of AEDs: _____	
Make & Model	Serial Number

STAT PADS LLC and its medical directors will be providing the AED prescription for the above site. The above site fully accepts the responsibility to provide all other legal and recommended requirements for AED placement. These requirements are designed to insure PAD program quality and readiness and include, but are not limited to: medical control and oversight, ongoing training, event review, policies and procedure updates, equipment maintenance, and ongoing AED program compliance.

The above site fully releases STAT PADS LLC from any liability associated with the AED.

Name: _____

Signature: _____

Date: _____