



AED Post-Incident Detailed First Aid Report Form

December 2025

This form must be completed for every incident necessitating AED use.

Patient's Last Name:	Patient's First Name:	Date of Incident:
Patient's Address:		Name of person applying AED:
Exact Location of Incident (include building name, room #, details):		
Time of Incident: am pm	AED Serial Number:	Assistant:
Estimated time from patient's collapse until CPR begun:		Estimated total time of CPR until Application of AED:
Was Cardiac Arrest Witnessed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If so, by Whom?	Time:
Was CPR started? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If so, by Whom?	Time:
Description of Incident:		
Report Completed By:		Date:
District Principal (OHS) Reviewed:		Date

- ❖ Submit completed form **within 24 hours** via email to the District Principal responsible for Occupational Health and Safety.
- ❖ Include the digital printout generated from the AED after use.