



Vermont Emergency Medical Services District Number Three
Fletcher Allen Health Care
Medical Center Hospital of Vermont Campus
Medical and Health Care Information Center
Burlington, VT 05401

Annual Cardiac Arrest Report

Directions: Complete this form each year during the month of June. Documentation must include three (3) skill review check-offs every 4 months (recommended months to be September, January, and May) based on the service's approved AED and advanced airway Quality Improvement Plan. This report may be subject to review by Medical Direction - services are NOT required to submit a copy to Medical Direction unless requested. Complete both sides of this form.

Abbreviations: **A** = AED **E** = ETI **CT** = Combitube **AA** = AED and advanced airway

Service Name: _____ **Date Submitted:** ___/___/___

Circle skill and list dates for any of the following Q.I./case review sessions:									
A - E - CT - AA	___/___/___	A - E - CT - AA	___/___/___	A - E - CT - AA	___/___/___	A - E - CT - AA	___/___/___	A - E - CT - AA	___/___/___
A - E - CT - AA	___/___/___	A - E - CT - AA	___/___/___	A - E - CT - AA	___/___/___	A - E - CT - AA	___/___/___	A - E - CT - AA	___/___/___
A - E - CT - AA	___/___/___	A - E - CT - AA	___/___/___	A - E - CT - AA	___/___/___	A - E - CT - AA	___/___/___	A - E - CT - AA	___/___/___

Please describe public education activities provided during the past year:

Please describe any issues related to cardiac arrest management that you would like feedback on. Use this section to list members who have joined or left the service:

_____ Signature of Service AED Coordinator	_____ Signature of Service ETI Coordinator
_____ Signature of Local Medical Advisor	___/___/___ Date

Complete both sides of this form

