

**Mile-High Regional Emergency and Trauma
Advisory Council (MHRETAC)**

 **AED Request Application**

The Mile-High Regional Emergency and Medical Advisory Council (MHRETAC) seeks to ensure that the greatest possible public good comes from placing its grant-available resources into public use. This questionnaire will assist us in determining the need for an AED in this location. No questions are considered disqualifying. The MHRETAC strives to determine that suitability of the applicant and facility to ensure that these resources are matched with mutual goals and serve the greatest good.

Please complete this document in its entirety and return to Shirley Terry, Executive Director, MHRETAC at shirleyterry@comcast.net

Please refer to Colorado Revised Statutes, C.R.S. 13-21-108.1 (2015)
for information regarding persons rendering emergency assistance through the use of automated external defibrillators- limited immunity.

**Date of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Person Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please describe the nature of your organization or business, its hours of operation, organizational structure and public access:**

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**Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**According to the MHRETAC AED Request Guidelines, there is a 50/50 cost share requirement for private (for-profit entities). Are you a private entity? Please describe your business type.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you are a private entity, please indicate the source of funding for the match.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please describe the financial need to support the request for this AED.**

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**In a week, approximately how many people aged 25+ would be in your facility, and would be within the vicinity (within 90 seconds walk time) of the AED should it be needed?**

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**Describe the risk populations that you serve that would benefit from the placement of an AED in your facility.**

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**Has your organization experienced a cardiac-related event; or what has prompted your organization to investigate an AED for your facility at this time?**

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**Are there any other resources we might be able to use to learn more about your organization/business? Any additional comments?**

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**Number of AEDs Requested\_\_\_\_\_\_\_\_\_\_\_\_\_**

If only a partial award is granted, how many AEDs would be needed to start your program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Proposed Location of AED:**

Name of Building or Site **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

City, State and Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this location a private business location or public-access location? \_\_\_\_\_\_\_\_\_\_

**Contact Person at the AED Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please complete the following written plans:**

**Deployment Plan:**

 **Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Access:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Type of AED:**

 **Who will deploy the device? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **How will 911 be notified?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Education Plan:**

**Describe the CPR training level of employees**

**Identify the type of personnel authorized to use AEDs**

 **Notification to local 911 authorities of AED placement
 Identify the local EMS system associated with this plan**

**Medical Oversight:**

 **Complete the attached MHRETAC AED/Defibrillator Medical Authorization form, signed by the physician and attach it to this request**

**AED Utilization:**

 **All use of the AED must be reported immediately to your associated EMS provider**

**Maintenance Plan:** AED must be maintained and tested according to the manufacture’s operational guidelines with written records maintained of this maintenance and testing.

 **Monthly Testing**

 **Pad replacement**

 **Battery replacement**

**C.R.S. 13-21-108.1 (2015)**

**Requestor verifies that the attached Colorado Statue has been provided to the recipient of the requested AED Donation.**

**Verification Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Describe the reasoning for the AED at this proposed location:
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**­­­­­­­­­­­­­­­­­­­How will an AED benefit the community at this proposed location?
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**Have other avenues of funding been explored? Please explain the outcome and identify the entity where you requested funding.
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 **Attachments:** AED/Defibrillator Medical Authorization
 C.R.S. 13-21-108.1 (2015)
 AED Donation Agreement

**Note:** This AED Request Application and AED/Defibrillator Medical Authorization must be attached for review by the MHRETAC Grants Committee for consideration.

It is very important for the MHRETAC to understand and have a clear picture of our applicants to match appropriately to these resources. Thank you for taking the time to help us understand more about your organization and applying for our AED Grant Program. You will be notified via e-mail of the outcome of this request. Please note that the MHRETAC Grants Committee meets every other month just prior to the MHRETAC. Therefore, please submit your requests accordingly.

***MHRETAC AEDs are provided by the funds generated from the MHRETAC fund-raising events such as the Annual Golf Tournament and the Clay Shooting Events.***

***November 2024***