

Automatic External Defibrillator (AED) Medical Authorization

The Food and Drug Administration considers defibrillators to be prescription devices pursuant to 21 CFR 801.109 and medical authorization is required.

This document provides Medical Authorization for one or more Automatic External Defibrillator(s) ("AED(s)") as indicated below:

1. Recipient of the AED Medical Authorization (check all that apply):
 - Individual/Patient
 - Business: number of locations _____
 - Educational: number of locations _____

2. Name of recipient of AED(s): _____

3. Address for each AED location:

Location Name: _____

Street: _____

City/State/Zip: _____

Phone Number: _____ E-mail: _____

Contact/Title: _____

If more locations are provided for under this Medical Authorization, please attach a separate sheet of paper listing the required contact information for each location.

List any restrictions to this Medical Authorization, if applicable: _____

Authorizing Physician (please print):

Name: _____

Street: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Physician's Signature: _____ Date: _____

Return to:

Start A Heart
651 East 4th Street
Suite 100
Chattanooga TN 37403
Fax: 423-634-3249
Phone: 423-648-9830



651 East 4th Street – Suite 100
Chattanooga TN 37403

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Additional Addresses

Location Name: _____

Street: _____

City/State/Zip: _____

Phone Number: _____ E-mail: _____

Contact/Title: _____

Location Name: _____

Street: _____

City/State/Zip: _____

Phone Number: _____ E-mail _____

Contact/Title: _____

Location Name: _____

Street: _____

City/State/Zip: _____

Phone Number: _____ E-mail _____

Contact/Title: _____

Location Name: _____

Street: _____

City/State/Zip: _____

Phone Number: _____ E-mail _____

Contact/Title: _____