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| Monthly Inspection and Maintenance |  |
| Location AED:       | Type of AED:       |
| Year:       | Serial No.:       |
|  | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **July** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** |
| AED present, clean and in good condition |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| One set of ADULT defibrillator pads, sealed, undamaged, and in date. |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Scissors, disposable razor, one-way filter mask, 4-inch gauze, towel, antiseptic wipes and 2 pairs of gloves available in good condition. |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Spare battery (if applicable) |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Status indicator(hourglass self-test passed) |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| Wall cabinet alarm is in proper working condition (if applicable) | [ ]  |[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]
| **INSPECTOR INITIALS:** |       |       |       |       |       |       |       |       |       |       |       |       |
| Problems Noted |  |  |  |  |  |  |  |  |  |  |  |  |
| Corrective Action(s) Taken |  |  |  |  |  |  |  |  |  |  |  |  |

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| Instructions |
| * Please ensure at least one (1) set of adult pads and one (1) set of child pads are in the AED cabinet. Ensure that the pads are not expired.
* Ensure that the battery is fully charged (if not, either replace it or re-charge it per the manufacturer’s specifications).
* All out-of-date or defective batteries should be replaced. The out-of-date and defective batteries should be properly discarded.
* All deficiencies should be reported to the AED Program Administrator for corrective action.
* If an AED needs to be taken out of service, please post signage reading “AED OUT OF SERVICE.”

This checklist is designed to help ensure your AED will always be ready when you need it most. All questions regarding the AED program at \_\_\_\_\_\_\_\_\_\_\_ should be forwarded to the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.Please forward completed checklist to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |

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| Reviewer |  |
| Signature:  | Date: Click or tap to enter a date. |