

# Department/Unit AED/CPR Team Roster

AED Location: \_\_\_\_\_ AED Director: \_\_\_\_\_  
 Dept/Unit Name: \_\_\_\_\_ Date: \_\_\_\_\_

	Name of AED Responder: (Please PRINT CLEARLY)	Office Phone Number	Cell Phone Number
1.			
2.			
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20.			

I confirm that the information contained on this roster is true and accurate, and all Responder training is up-to-date.

\_\_\_\_\_  
 Signature of AED Director

\_\_\_\_\_  
 Date