

New York State Office of General Services

**Agency AED Program Plan
AED Administrator and Secondary Representative**

Name: _____

I designate the people listed below as our Agency's representatives to the New York State AED initiative.

AED Administrator

Name: _____

Title: _____

Work Address: _____

Telephone No.: _____ Fax No.: _____ E-mail: _____

Secondary Representative

Name: _____

Title: _____

Work Address: _____

Telephone No.: _____ Fax No.: _____ E-mail: _____

Name of *prior* AED Administrator: _____

Agency Head/Designee

Mail To:
Robert Parete
Office of General Services
AED Program Director
39th Floor, Corning Tower
Empire State Plaza
Albany, NY 12242

Name

Signature

Date