

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:
Richard C. Lamendola
Office of General Services
AED Project Director
39th Floor, Corning Tower
Empire State Plaza
Albany, N.Y. 12242

Name

Signature

Date