

Application for a Permit for a Public Gathering

*APPLICATION FEE IS \$250 PAID BY _____

*THIS APPLICATION MUST BE RECEIVED BY THE TOWN BOARD NO LATER THAN 30 DAYS PRIOR TO THE DATE OF THE EVENT

Before completing this application be sure you are familiar with the provisions of part 18 of the New York State Sanitary Code; Part 800, the State EMS Code; and all other N.Y.S. and local laws or regulations which may apply to the event.

Event

Name of Event (as appearing in advertising) _____
Type of Event (fair, race, concert, etc.) _____

Specific Location of Event (Attach a local highway map and describe using name and address of a facility, property, roads, landmarks, etc.)

Name of Facility/Property _____
Facility Owned by _____
Address _____
City, State, Zip _____
County _____
Representative _____
Telephone No. (_____) _____ - _____ Email _____

Event Opens	Event Closes	Usual Hours of Event Operation	Anticipated peak Attendance on Site at Any One Time
Date _____	Date _____	_____ To _____	Date(s): _____
Time _____	Time _____	<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> AM <input type="checkbox"/> PM	Time(s): _____
<input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> AM <input type="checkbox"/> PM		Anticipated Peak Attendance # _____

Promoter/Operator of Event

Promoter _____	Operator _____
Name _____	Name _____
Email address _____	Email address _____
Permanent Address _____	Permanent Address _____
City, State, Zip _____	City, State, Zip _____
Name of Representative _____	Name of Representative _____
Title _____	Title _____
Mailing Address _____	Mailing Address _____
City, State, Zip _____	City, State, Zip _____
Telephone No. (_____) _____ - _____	Telephone No. (_____) _____ - _____

Insurance Coverage for Event

Carrier _____
Agent _____ Telephone No. (_____) _____ - _____
Limits of Coverage of Liability Insurance _____

EMS Provider (Agency or Individual who will provide, schedule and/or arrange for emergency medical services)

Name _____ Mailing Address _____
EMS Supervisor _____
Telephone No. (_____) _____ - _____ Email Address _____

Emergency Health Care (EHC) Facilities to be Provided at Event Site

NOTE: ALL EHC units will be staffed to the provisions of 18.4. Other Medical personnel may be included.
If ambulance(s) are being used as an (EHC) do not duplicate them in the number of vehicles in the ambulances on site section of this form.

Type	Reference	Number Provided	Description of Owner
Sheltered Facility	18.1.b		
Ambulance Vehicle (s)	18.2.f		

Describe How EMS Services May Be Accessed During the Event.

(Identify all requirements on site map and attach additional sheet if necessary):

By Security or EMS Patrol Teams (specify and describe below and identify Zone(s) or station(s) on site map).

Emergency telephone system on site, describe below and identify locations on site map.

Other; describe below: _____

How will EHC's and their locations be identified or announced to the public _____

Describe EMS Response to a patient (Attach additional sheet if necessary):

(Describe how EMS gets to the patient and the patient to an EHC facility)

Advanced Life Support Services

Will Be Provided on Site Yes No

If Yes, Agency Providing: _____ ALS Level: AEMT Critical Care Paramedic

Medical Control Facility _____

Physician Medical Director _____

Hospitals

Hospital Name and Address	ER Contact Number(s)	Distance from Event Location	Trauma Center	Burn Center	STEMI Center	Stroke Center	HELI-Pad
_____	_____	_____	<input type="checkbox"/> Yes Level: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes Level: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes Level: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes Level: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes Level: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Attachments (application will not be accepted without all of the following)

This Application Must Include the Following:

1. Site Map

Prepare and attach a detailed map of the site showing all prominent physical features of the event site including but not limited to:

- a) Location of emergency health care facilities
- b) Location of any on site ambulance(s)
- c) Emergency telephones
- d) EMS Patrol team zones or stations
- e) Site and security perimeters
- f) Spectator and participant areas
- g) Access and exit routes (normal and emergency)
- h) Major buildings, structures, physical features
- i) Helicopter landing sites
- j) Extraordinary hazards

- 2. A list of any special equipment or vehicles (including tourniquets or ATV's) to be provided in addition to that required by part-18.
- 3. Any emergency medical standard operating procedures, operational plans, protocols and/or disaster plans to be used during the event.
- 4. A schedule of medical personnel (EMT's, nurses, M.D's) who will staff the EHC's and the event or the agency(s) who will supply staff.
- 5. Copies of notifications provided to local, municipal and public safety officials, hospital emergency departments, including police, fire and local emergency medical services personnel. (Reference 18.4).
- 6) Please provide a copy of a statement from the lead law enforcement agency for your event stating they have in place an Active Shooter as well as an Improvised Explosive Device plan. Do not provide any law enforcement sensitive information as an attachment to this application.
- 7) an Incident Action Plan (IAP) should be included with this application.

By Submitting this application, the undersigned agrees on behalf of the 'promoter or operator' to operate the public function herein described in compliance with Part 18 of the Sanitary Code, Part 800 of the State EMS Code and any other laws, regulations or stipulations imposed by state or local authorities. The applicant testifies to the accuracy of this application.

Name of Applicant _____ Date of Application: ____ / ____ / ____

Title of Applicant _____

Applicant's relationship to Promoter or operator _____

Applicant's Signature _____

Applicant's email address phone number _____

NOTE: Applicant must be an officer or other representative of the promoter or operator. A digital or original signature is acceptable for submission of this application.