NEW YORK STATE DEPARTMENT OF HEALTH
Emergency Medical Services

Application for a Permit for a Public Gathering

- **THIS APPLICATION MUST BE RECEIVED BY THE DEPARTMENT NO LATER THAN THE EARLIER OF FIVE (5) DAYS BEFORE THE FIRST DAY OF ADVERTISING OR FIFTEEN (15) DAYS BEFORE THE FIRST DAY OF THE EVENT.**
- **THE ADVERTISING, PROMOTION OR OPERATION OF A PUBLIC FUNCTION WITHOUT THE APPLICABLE PERMIT(S) IS A VIOLATION OF THE NEW YORK STATE SANITARY CODE AND IS A VIOLATION OF STATE LAW.**
- **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.**

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		Facility Operated by	
Address		Address	
City, State, Zip		City, State, Zip	
County		County	
Representative		Representative	
Telephone No.		Telephone No.	

Event Opens	Event Closes	Usual Hours of Event Operation	Anticipated Peak Attendance On Site at Any One Time
Date _____	Date _____	_____ AM PM TO _____ AM PM	Date(s) _____
Time _____ AM PM	Time _____ AM PM		Time(s) _____ AM PM

Promoter/Operator of Event

Promoter:		Operator:	
Name		Name	
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 _____

EMS Supervisor _____

Mailing Address _____ Telephone No. ____ _____

DOH-44(6/88)

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

TYPE	REFERENCE	NUMBER PROVIDED	DESCRIPTION OF OWNER

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)

_____

_____

_____

_____

Event Site Communications Capabilities

Telephone number(s) on site: (____) _____ (____) _____
A/C A /C

	EMERGENCY ACCESS PHONE NUMBERS	AGENCY NAME	CONTACT PERSON
Police			
Fire			
Ambulance			
Other			

2 way Radio On-site Frequency _____ MHz: FCC License Number_____

Base Unit: frequencies available _____ MHz Tx Power _____ Watts

#_____ Mobile(s): frequencies available _____

#_____ Portable(s): frequencies available _____ Tx Power _____ Watts

Advanced Life Support Services

Will Be Provided on Site YES NO

If Yes

Agency Providing _____

ALS Level: ☐ Intermediate ☐ Critical Care ☐ Paramedic

Medical Control Facility _____

Physician Medical Director _____ Telephone No. _____

On line Medical Control: ☐ On site ☐ UHF radio ☐ VHF radio ☐ Phone Telemetry available YES NO

Ambulance Vehicles for Off Site Transportation

Owner/Operator	Phone Number	Number of Vehicles	Location during event

Hospitals

Name of Hospital	ER phone number	Location	Distance from site

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 to be provided in addition to that required by Part-1 8.
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) which will supply staff.
5. Copies of municipal and public safety agency statements of notice: (Reference 18.4).

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 _____

NOTE: Applicant must be an officer or other representative of the promoter or operator.

Notary Public Endorsement

Additional Information to Support Application:

FOR OFFICE USE ONLY

Application Review and Recommendations

Permit Issued:

DATE: _____

NUMBER: _____

ISSUING OFFICE: _____

Date Application Received: _____

Permit Expiration Date: _____

Recommendations/Permit Conditions _____

Variances/Modifications to Equipment or Staffing Recommended

it is recommended that a permit be issued to the event described in this application

Recommended by _____ Title _____ Date _____

Mass Gathering and Public Functions
Fee Determination Schedule

NEW YORK STATE DEPARTMENT OF HEALTH

As required by Article 6, PHL. effective 1/1/88

Fee Exemption Requested? ☐ Yes If Yes, complete sections A, C and D and return. ☐ No

FOR OFFICE USE ONLY
Cashline #
Amount $
Received by

INSTRUCTIONS
Print or type the requested information. Determine the correct fee. Make your check payable to the New York State Department of Health. Mail the completed form and your check to the appropriate Department of Health Regional or District Office within 30 days of receipt of this form.

SECTION A

1 1a Name of Establishment _____

b Address (No & Street, City, State, Zip) _____

2 Name of Operator _____ Title _____

SECTION B

1 Check the appropriate category

Mass gatherings, including Plan Review	$500 00	
Public Functions of over 5,000 people not constituting mass gatherings		_____
Less than 3 emergency health care units	$100 00	_____
3 or more emergency health care units	$200 00	_____
	TOTAL FEE DUE	_____

SECTION C - Exemption Request

1 Is this facility Used for religious, educational or philanthropic purposes? Yes No

2 Is this facility operated by a municipality (city,town,village)? Yes No

3 If the answer to questions 1 or 2 is "yes you may request exemption from payment of the annual registration fee Please indicate documentation that will be made available upon inspection request.

Incorporation Papers _____ Other (specify) _____

SECTION D - Certification

False Statements on this application are punishable under article 170 of the Penal Law.

I hereby certify that the statements made on this form are accurate to the best of my knowledge

Signature of Operator _____ Date _____

NEW YORK STATE DEPARTMENT OF HEALTH
Emergency Medical Services

Part 18
Public Function Event Report

INSTRUCTIONS:
This report is to be completed by the operator of any event permitted under the authority of New York State Sanitary Code Part-18, and forwarded to the Emergency Medical Services representatives at a Health Department Regional Office no more than five days following the event. The filing of this report is a condition of the issuance of the permit, and must be completed for any permit issued and/or each and every single event covered by a seasonal permit.

Name of Event

Type of Event

Date(s) of Operation

Total Event Attendance

Actual Peak Attendance

Medical Incidents	**No.** of Patients Treated
Minor Injury(s) (cuts, scrapes, etc.)	
Major Injury(s) (fractures, head injury, etc.)	
Minor Illness(es) (sick, weak, heat, intoxication, etc.)	
Major Illness(es) (cardiac, allergic reaction, etc.)	
Deaths	
TOTAL PATIENTS TREATED - all causes	
Identify from the total number of patients treated during the event the number who showed signs or symptoms of any form of intoxication or substance abuse.	
Ambulance Transports	
Total patients transported from the site to local hospitals	

Unusual Occurrences/Comments (MCI, extreme weather conditions, etc.)

Completed by:

Print Name

Telephone Number

Title

Signature

Date

DOH 2332 (6/88)