

- 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 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.**

## 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 \_\_\_\_\_  AM  PM  AM  PM Time(s): \_\_\_\_\_  
 AM  PM  AM  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 \_\_\_\_\_

**Ambulances On Site During the Event**

Ambulance Service	Contact Number(s)/Frequency	Number of Vehicles	Location During Event	Level of Service
_____	( ) - _____	MHz _____	_____	<input type="checkbox"/> ALS <input type="checkbox"/> BLS
_____	( ) - _____	MHz _____	_____	<input type="checkbox"/> ALS <input type="checkbox"/> BLS
_____	( ) - _____	MHz _____	_____	<input type="checkbox"/> ALS <input type="checkbox"/> BLS
_____	( ) - _____	MHz _____	_____	<input type="checkbox"/> ALS <input type="checkbox"/> BLS

**Ambulance Vehicles for Off Site Transportation** (EMS System Ambulances to be called if additional ambulances are required)

Ambulance Service	Contact Number(s)/Frequency	Number of Vehicles	Has Agency Been Notified of Your Event	Level of Service
_____	( ) - _____	MHz _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ALS <input type="checkbox"/> BLS
_____	( ) - _____	MHz _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ALS <input type="checkbox"/> BLS
_____	( ) - _____	MHz _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ALS <input type="checkbox"/> BLS

**Event Site Communications Capabilities**

Telephone number(s) on site: ( ) - \_\_\_\_\_ ( ) - \_\_\_\_\_ ( ) - \_\_\_\_\_

	Emergency Access Phone Numbers	Agency Name	Contact Person
Police	( ) - _____	_____	_____
Fire	( ) - _____	_____	_____
Ambulance	( ) - _____	_____	_____
Other	( ) - _____	_____	_____

**On Site Communications**

Radio Type (Base/Mobile/Portable)	Channel ID	Function (EMS/Police/Fire/Event)	Role	Remarks
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Hospitals**

Hospital Name and Address	ER Contact Number(s)	Distance from Event Location	Trauma Center	Burn Center	STEMI Center	Stroke Center	HELLI-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 \_\_\_\_\_

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

Notary Public Endorsement



# Mass Gathering and Public Functions Fee Determination Schedule

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

**FOR OFFICE USE ONLY**

Cashline # \_\_\_\_\_

Amount \$ \_\_\_\_\_

Received by \_\_\_\_\_

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

## 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

- 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              | \$ _____        |
|  | <b>TOTAL FEE DUE:</b> | <b>\$ _____</b> |

## 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 or 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 \_\_\_\_\_