

Medical First Response Division
Request for First Aid Coverage Form

Please submit at least 6 weeks in advance, duties are covered on a first come, first serve basis.
Please print and ensure that all areas are completed.

Name of Organization:		
Registered Charity Number (if applicable):		
Contact Person (First & Last Name):		
Address:		
City:	Province:	Postal Code:
Daytime Phone Number:		Evening Phone Number:
Fax Number:		Email:

Event Name:	
Description of Event (i.e. Picnic, Concert, Sporting Event):	
Contact Person(s) at Event with Location Phone Number:	
Location of Event:	
Date:	Start & End Time:
Date:	Start & End Time:
Date:	Start & End Time:
Date:	Start & End Time:
Date:	Start & End Time:

Attach the following if available or applicable:	
<input type="checkbox"/> Proposed Route Map	<input type="checkbox"/> Tentative Site Layout
<input type="checkbox"/> Schedule	<input type="checkbox"/> Rain Out Plans
Are the following available on site?	
<input type="checkbox"/> First Aid Room	<input type="checkbox"/> Clean Drinking Water
<input type="checkbox"/> Telephone	<input type="checkbox"/> Parking
Do you require first aid coverage to meet your insurance/organizational requirement/policy?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coverage is requested for (please give approximate numbers)	
Age Group: _____	Participants: _____
Spectators: _____	Both: _____
A Site Assessment can assist you with layout plans, potential hazards and organization. Would you like to be contacted to discuss whether or not this is beneficial to your event?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will food and beverage be offered at no cost to St. John Ambulance Volunteers?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, where will this food and beverage be made available?	
Additional Information & Other Comments:	
I understand that the Medical First Response Division of St. John Ambulance is a volunteer program. I acknowledge that I will be contacted at minimum 2 weeks before the event to let me know if coverage is available. I understand that a fee is associated with this service and an invoice will be sent to me prior to my event based on the number of hours and service needed. Payment for this service is to be made after my event. The "Event Classification Reference Information" can be used as a guide to determine appropriate fee.	
Signature:	Date:

For more information please call 905-356-7340

Office Use Only:

Date Requested Receive:
Date Called to Confirm Receipt of Request:
Date Event Confirmed or Denied:
Signature:
Other Communications:

EVENT CLASSIFICATION REFERENCE INFORMATION

PLEASE FILL OUT THE APPROPRIATE SECTION, SIGN AND RETURN WITH DUTY REQUEST

Event Name: _____
<p>Your event is classified as NOT-for-Profit if ALL of the following are true:</p> <ul style="list-style-type: none"> • There is NO money made OR donation to ANY part of the organization itself, and • ALL expenses are covered through donations or sponsorship, and • ALL monies collected are donated to charities other than the organization itself, and • NO members of the organization are paid for their services. <p>If your event meets the NOT-for-PROFIT classification we ask that you provide a suitable donation to “St. John Ambulance – Niagara Falls Branch”, to help us cover expenses (e.g.: fuel, first aid supplies, etc...) We will be making a donation of \$ _____</p>
<p>Your event is classified as FOR-Profit if ANY of the following are true:</p> <ul style="list-style-type: none"> • Monies are collected at the gate, or • There is expected income from the sale of merchandise, food, liquor, etc, or • Money collected will be used to cover expenses incurred for running the event, or • ANY member (staff or volunteer), of the organization is reimbursed for personal expenses, or • ANY member is paid directly or indirectly for their services. <p>If your event meets the For-Profit classification, our standard cost-recovery donation is \$45/hr, which includes 2 uniformed Medical First Responders and mobile first aid post.</p> <p>Number of hours services are requested \$ _____ x45= \$ _____</p>
<p>Requests for reconsideration if your event is FOR-Profit and of long duration (greater than 10 hours):</p> <p>We are sensitive to the fact that events longer in duration can incur significant expenditures. We acknowledge that after 10 hours our cost of covering and event become somewhat reduced, vehicle and supply usage dependent. In the interest of Community Service we can make arrangements fit your budget. If your event is longer than 10 hours, please provide the following information in Section 4 for consideration;</p> <ul style="list-style-type: none"> • Projected gross income(based on past 5 years), • Projected total expenditures (Based on the past 3 years). • Any pre-considered donation to St. John. <p>Estimated Gross Income: \$ _____</p> <p>Total Expenses: \$ _____(not including First Aid Services)</p> <p>Suggested Donation to St. John Ambulance: _____</p>
<p>PLEASE NOTE: That ALL cheques are payable to “St. John Ambulance - Niagara Falls Branch” and should be mailed directly to the Branch, attention of the Branch Manager</p>