NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services and Trauma Systems

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 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 _____

Name _____

Email address _____

Permanent Address _____

City, State, Zip _____

Name of Representative _____

Title _____

Mailing Address _____

City, State, Zip _____

Telephone No. (_____) _____ – _____

Operator _____

Name _____

Email address _____

Permanent Address _____

City, State, Zip _____

Name of Representative _____

Title _____

Mailing Address _____

City, State, Zip _____

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 _____

Telephone No. (_____) _____ – _____

Mailing Address _____

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			☐ ALS ☐ BLS
	( ) – MHz			☐ ALS ☐ BLS
	( ) – MHz			☐ ALS ☐ BLS
	( ) – MHz			☐ ALS ☐ 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		☐ Yes ☐ No	☐ ALS ☐ BLS
	( ) – MHz		☐ Yes ☐ No	☐ ALS ☐ BLS
	( ) – MHz		☐ Yes ☐ No	☐ ALS ☐ 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	HELI-Pad
____________	______	______	☐ Yes Level:__	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
____________	______	______	☐ Yes Level:__	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
____________	______	______	☐ Yes Level:__	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
____________	______	______	☐ Yes Level:__	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
____________	______	______	☐ Yes Level:__	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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.

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services and Trauma Systems

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	$ _____
	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 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** _____

FOR OFFICIAL USE ONLY – Additional Information to Support Application

Use additional forms as necessary.

FOR OFFICIAL USE ONLY – Application Review and Recommendations

Date Application Received _____ /_____ /_____

Permit Expiration Date _____ /_____ /_____

Recommendations/Permit Conditions _____

Permit Issued

Date _____ /_____ /_____

Number _____

Issuing Office _____

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 _____ /_____ /_____