EAST BOISE COUNTY EMS DISTRICT (EBCED)

SPECIAL EVENT MEDICAL COVERAGE APPLICATION

APPLICATION INSTRUCTIONS

Applications must be submitted a minimum of 90 days- small events, 120 days- large events prior to the event. Submission does not guarantee coverage. Coverage is subject to staffing availability, operational needs, and approval by EBCED Administration.

EVENT INFORMATION

Event Name: _____

Event Type: _____

Organization: _____

Primary Contact: _____

Phone: _____

Email: _____

Event Date(s): _____

Coverage Start Time: _____

Coverage End Time:_____

Event Address/Location: _____

GPS Coordinates: _____

Estimated Attendance: _____

Estimated Participants: _____

For Professional Sporting Events (if applicable) If a sports medicine group will be providing medical care for participants at your event, please indicate their name.

_____

EMS COVERAGE REQUEST

☐ 1 Basic Life Support Ambulance (staffed with 2 EMT-Basics)

☐ 2 Basic Life Support Ambulances (each staffed with 2 EMT-Basics)

☐ Medical Treatment Area-First Aid Station (staffed with 2 EMT-Basics)

☐ Mobile Medical Team (2 EMT-Basic with Medical Bag, AED, and UTV- locations off main road -this is required)

CHECKPOINT COVERAGE REQUIREMENTS

IMPORTANT:

- EACH CHECKPOINT REQUESTED FOR COVERAGE REQUIRES A MINIMUM OF TWO (2) EMTS.
- Staffing costs are assessed per checkpoint.
- UTV CHARGES WILL APPLY- ANY CHECKPOINT NOT ACCESSIBLE BY MAIN ROAD.
- UTV, COMMAND, OR SUPERVISOR RESOURCES MAY BE REQUIRED BASED ON TERRAIN, DISTANCE, ACCESSIBILITY, AND OPERATIONAL RISK.
- Resource requirements and associated fees shall be determined by the Chief of Operations, Assistant Chief, Commissioners or designated Supervisor.
- Additional staffing required for high-risk events.

CHECKPOINT #1

Checkpoint Name: _____

GPS Coordinates: _____

Checkpoint Location Description:

_____

_____

Accessible by Main Road?
☐ Yes ☐ No

Special Hazards/Notes:

_____

_____

CHECKPOINT #2

Checkpoint Name: _____

GPS Coordinates: _____

Checkpoint Location Description:

_____

_____

Accessible by Main Road?
☐ Yes ☐ No

Special Hazards/Notes:

_____

_____

CHECKPOINT #3

Checkpoint Name: _____

GPS Coordinates: _____

Checkpoint Location Description:

_____

_____

Accessible by Main Road?
☐ Yes ☐ No

Special Hazards/Notes:

_____

_____

CHECKPOINT #4

Checkpoint Name: _____

GPS Coordinates: _____

Checkpoint Location Description:

_____

_____

Accessible by Main Road?
☐ Yes ☐ No

Special Hazards/Notes:

_____

_____

_____

Any additional check points please attach extra page

RADIO and INJURY REPORTING OPERATIONS INFORMATION

Radio Communications Plan Attached?
☐ Yes ☐ No

Injury Reporting Plan Attached?
☐ Yes ☐ No

APPLICATION ACKNOWLEDGEMENT

By signing AND initialing this application, the applicant acknowledges and understands:

_____ This application is not a contract.

_____ Submission of this application does not guarantee EMS coverage.

_____ The event must be approved by the East Boise County EMS District Board of Commissioners.

_____ Approval is contingent upon completion of a safety walk through conducted by an EBCED Staff Officer.

_____ EBCED may require modifications to the event medical plan prior to approval.

_____ A formal Event Medical Services Agreement will be issued following commissioner approval.

_____ No EMS coverage is guaranteed until a formal contract has been fully executed.

_____ Each checkpoint requested for coverage requires a minimum of two (2) EMTs.

_____ UTV charges apply to checkpoints not accessible by maintained roadway.

_____ Additional staffing, supervisor, command, UTV, Jeep, or specialty resources may be required based upon EBCED's risk assessment.

_____ EBCED retains the authority to redeploy resources during emergencies, disasters, or mass casualty incidents occurring within the district or mutual aid response area.

EVENT ORGANIZER CERTIFICATION

I certify that all information provided is accurate and complete.

Applicant Name: _____

Title: _____

Signature: _____

Date: _____

FOR EBCED USE ONLY

Date Received: _____

Reviewed By: _____

Risk Level:
☐ Low
☐ Moderate
☐ High
☐ Extreme

Coverage Approved:
☐ Yes
☐ No

Resources Assigned:
☐ One Ambulance
☐ Two Ambulances
☐ UTV Team(s)
☐ Command Unit
☐ Supervisor
☐ Additional Personnel

Estimated Cost: _____

Chief of Operations Approval:

Signature: _____

Date: _____