

EMS Plan for Special Event/Mass Gathering					
1. Event Name/Type:			2. Alcohol at Event: Y / N		
3. Operational Period(s) (OP's):					
4. Primary Permitting Agency/Contact:					
5. Total # of Attendees (per OP):			6. Max. Attendees at one time (per OP):		
7. Event Footprint Description/Location(s):					
7. Incident Medical Aid Stations					
Level of Service:	Location	# MD's/RN's		# EMT/EMT-P's	# AED's
8. #/Types of Mobile Teams		9. Locations of Mobile Teams			
10. Dedicated Non-Transport Medical Provider(s):					
Company Name/Contact:		Address:		Phone:	
11. Dedicated ALS Transport Medical Provider(s):					
Ambulance Provider Name	Address	Phone	Contact	# Ambulances	
				Dedicated	Courtesy
12. Plan Collaborators (Involved Agencies/Service Providers/Secondary Permitters):					
Contact:	Phone:	Email Address:	Agency/Company:		
13. Acceptance of Responsibilities:					
<p><b>You Must:</b></p> <ul style="list-style-type: none"> <li>• Submit List of all Medical Staff, NOT employed by a permitted CCSF Ambulance Provider, no less than one (1) week prior to Operational Period (OP).</li> <li>• Contact Dispatch Supervisor (415/575-0737) before/after event to identify responsible party (Name/Phone #) for <b>EACH</b> Operational Period (OP).</li> <li>• Ensure that CPR/AED's are available at all Aid Stations and with Mobile Teams</li> <li>• Ensure that there is at least one (1) MCI Kit present at event, and that staff are trained in its use.</li> <li>• Submit all Event Maps and Supplemental Documents, with this form, to:  <a href="mailto:EMSMedicalPlans@sfdph.org">EMSMedicalPlans@sfdph.org</a></li> </ul>					
14. Prepared by: _____					
Contact information: (Email & Phone): _____					
15. Signature/Date:					

Please use additional blank pages, as necessary.

Please submit this form, with all supplemental documents, to [EMSMedicalPlans@sfdph.org](mailto:EMSMedicalPlans@sfdph.org)