AFFILIATE INTENT TO COVER

A Special Event is any activity outside of the normal place of business for the affiliate. This form should be completed and submitted to the EMS agency having jurisdiction at least 2 weeks prior to the event.

Date of submission_________________ Date of event______________________

Name of affiliate Agency____

Name & phone number of contact from affiliate agency____________________________

Time of coverage for event: Start___________________ Stop______________________

Name of event____

Location(s) of event____

Name and contact phone number for event supervisor___________________________________

List specific locations and times where services will be provided___________________________
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Overview of event____

Communication plan: Specifically, what method will be used to contact 911__________________
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1. Affiliate Agency proof of insurance on file with Spokane County EMS: ____Yes _____No
2. Affiliate Agency current business license or alternative state/federal paperwork on file with Spokane County EMS. _____Yes _____No
3. All personnel working under the affiliate agency DOH approval for this even event have current Washington State certification. _____Yes _____No
4. All personnel have current knowledge of Spokane County Protocols and East Region Patient Care Procedures. _____Yes _____No
5. Indicate numbers and levels of certification that will be providing service at the event.
   FR_____ EMT_____ ILS_____ PM_____ Other_____
6. List equipment and supplies available on site for use by EMS Personnel.

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Affiliate agency representative signature____

Jurisdictional Agency Review ___Yes ___No Date_____________________________________

Jurisdictional Agency Representative Name________________Signature__________________

Copy sent to affiliate agency. ___Yes ___No Date_____________________________________