



Request for Volunteer Medical First Response Coverage

Name of Group/Organization: _____

Contact Person: _____ Title: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

E-mail Address: _____

Residence Phone #: _____ Business Phone #: _____

Cell Phone #: _____ Fax #: _____ *(Privacy Statement on reverse side)*

Event

Name: _____ Type: _____

Location: _____

Date(s): _____	Alternate Date: _____	Time Start: _____	Finish: _____
_____	(Rain) _____	_____	_____
_____	_____	_____	_____

Arrival: _____	Departure: _____	Name of Contact at the event: _____
_____	_____	_____
_____	_____	_____

Attach the following if available or applicable:
 Proposed Route Map Tentative Site Layout Schedule Rain Out Plans

Are the following available on-site?
 First Aid Room Clean Drinking Water Telephone Parking

Special Equipment requested: _____

Coverage is requested for: (Please give approximate numbers)
 Participants _____ Spectators _____ Both _____ Age Group: _____

If the event is longer than four (4) hours or at meal time(s),
Is food available on site? Yes No

Is complimentary food available for our volunteers?
Please specify (i.e. coffee, lunch etc.)

Will your organization/group provide us with a donation? Yes No Suggested donation amount: _____
Will you require a receipt? Yes No

Additional information/special comments:

Signature _____ Date: _____

Mail request to:

OR

FAX:

Attention:

For best service, please place your request early.

The minimum notice required is: _____

PRIVACY STATEMENT

St. John Ambulance respects the information of its volunteers and event sponsors. This information you have provided will be used to assess service requirements, including pre-event requirements, post-event evaluation, service related fees, outcome measures and repeat follow-up. We may contact you from time to time to update our records and/or ensure the accuracy of the information. The personal information you provide will not be shared or disclosed without your prior written consent. Should you have any questions regarding St. John Ambulance's privacy policy, you may view our policy online at www.sja.ca or contact the Privacy Officer at your respective Provincial/Territorial St. John Ambulance Office.

FOR OFFICE USE ONLY

Date request received: _____

Assigned CSU: _____

Confirmed CSU(s) with: _____

Date: _____

Event Confirmed with: _____

Date: _____

Request Denied:

- No personnel available
- Too many events already scheduled for this date
- Request received too late to fill
- Other

If "Other", please specify reason: _____

Evaluation of Coverage Form sent Yes No Date: _____

Request Form sent out for next time Yes No

Donation request sent out Yes No Date: _____ Donation received: Yes No Amount: _____