



St. John Ambulance

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 #: _____

Event

Name: _____ Type: _____

Location: _____

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

Arrival: _____	Departure: _____
_____	_____
_____	_____

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 complementary food available for our volunteers?

Please specify (i.e. coffee, lunch etc.)

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

FOR OFFICE USE ONLY

Date request received: _____

Assigned Division: _____

Confirmed Division(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

Evaluation of Coverage Form sent Yes No Date: _____

Request Form sent out for next time Yes No

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