The purpose of this document is to notify the ambulance service of your event is taking place. It allows for all the key information we need to be captured in one place.

Please complete the form below and return it to relevant area e-mail address, listed below no later than 4 weeks before your event.

|  |  |
| --- | --- |
| **Name of Event** |  |
| **Date(s) of Event** |  |
| **Times of Event** |  |
| **Location of Event** |  |
| **Event Mangers Contact Details** | **Name** |  | **Telephone Number** |  |
| **E-mail Address** |  |
| **Capacity (Licenced & Planned for)** |  |
| **How many attendees will be on site at any one time?** |  |
| **If there is overnight camping, how many will be camping?** |  |
| **As per section 5.6 of the Purple Guide, which tier level does your event fit into?** *Please tick*  |  | **Tier 1** |
|  | **Tier 2** |
|  | **Tier 3** |
|  | **Tier 4** |
|  | **Tier 5a** |
|  | **Tier 5b** |
|  | **Tier 5c** |
| **Medical Providers Contact Details** | **Company** |  | **Contact Name** |  |
| **E-mail Address** |  | **Telephone Number** |  |
| **Are they CQC registered?** |  | **Yes** | ***If yes, what is their CQC registration number?*** |
|  | **No** |  |
| **Medical Provision on Site**  | **Please provide the number of resources that will be on site at your event.** |
| **Resource** | **Quantity on Site** |
| **Personnel** | **Number of First Aiders / Responders** |  |
| **HCPC Registered Paramedics** |  |
| **NMC registered Nurses** |  |
| **GMC registered Doctors** |  |
| **IHCD Technicians/L4 Diploma for Associate Ambulance Practitioners:** |  |
| **Emergency Care Assistants:** |  |
| **Resources** | **Number of On Site First Aid Posts** |  |
| **Number of On Site Ambulances** |  |
| **Are these ambulances able to convey patients to hospital?** |  | **Yes** |  | **No** |
| **Please provide the CQC registration number of the ambulance provider who will be facilitating off site transfers to hospital from your event if it is not the same as your medical provider listed above.**  |  |
| **Patient statistics for previous years**  | **How many patients were seen at your event last year?**  |  |
| **How many patients conveyed to hospital last year?** |  |
| **How many NHS ambulances were called last year?** |  |
| **What is the process for allowing NHS ambulances through road closures / onsite event site in the response to a 999 call?** |  |
| **Please list any very high/ high risks associated with the event** |  |
| **Is there anything else you wish to tell us about your medical cover?** |
|  |
| **Have you provided a full medical plan alongside this document?**  |  |
| **Name of the Person Completing This Form** |  |
| **Role of the Person Completing This Form** |  |
| **Date Form Completed** |  |

**South Western Ambulance Service NHS Foundation Trust Area Event Contacts:**

Gloucestershire EPRR.gloucestershire@swast.nhs.uk

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