ECMRC Request Form

TODAY'S DATE: ____________________________

ORGANIZATION: ____

ADDRESS: ____

CITY: ______________________________ STATE: __________ ZIP CODE: _____________

TELEPHONE: _______________________ EMAIL: __________________________________

DATE ECMRC REQUESTED: _______/_______/_______ TIME: ______________________

LOCATION OF EVENT: ____

DESCRIPTION OF EVENT: ____

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PURPOSE: ☐Responder Awareness ☐Community Service

REQUESTING: ☐Information & Demonstration of Services
☐First Aid Support (Specify: ______________________________________)

Person Requesting ECMRC (Print Name): ____

Signature: ____

Please return this form by: email ECMRC@erie.gov, fax (716) 858-7121, or mail to Erie County Department of Health, ECMRC, 500 Commerce Dr, Amherst, NY 14228.
If you have questions, please call (716) 858-7101.

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FOR OFFICE USE ONLY

☐APPROVED ☐DENIED Reason: ____

ECMRC Administration (Print Name): ____

Signature: ____ Date: ______/_______/_______

Date Party Notified of Decision: ______/______/______

Updated 2/14/2024