Chautauqua County
Fire and Emergency Medical Mutual Aid Plan
Special Team Participation Authorization

The Participant named below is a qualified member of the Agency listed below and is authorized by the Chief of such agency and its supervising municipality* to act as an active Participant in the _____.
(insert name of specialized county team)

This authorization may be withdrawn at any time in writing by the Chief and the Supervising Municipality. Should the team Participant be dismissed from the team, the Fire Chief shall be notified.

Pursuant to the Chautauqua County Mutual Aid Plan, the Participant's Agency/Supervising Municipality acknowledge and certify that the Participant shall be covered by the Agency/Supervising Municipalities VFBL or WCB insurance coverage for all Special Team activities.

Participant's Name: _____

Participant's Address: _____

_____

Agency Name: _____

Chief's Authorization: _____

Supervising Municipality's Authorization: _____

Office of Emergency Services: _____

Team Leader: _____

_____DATE APPROVED _____DATE SEPARATED

*The town, village, city, or fire district in which the agency is situated.

Revised 8-16-17