CENTRAL DUPAGE HOSPITAL
EMERGENCY MEDICAL SERVICES SYSTEM

25 NORTH WINFIELD ROAD
WINFIELD, IL 60190

PHONE: 630.933.6910
WEBSITE: WWW.CDHEMS.COM

ECRN RIDE TIME VERIFICATION FORM

THIS FORM IS TO BE COMPLETED IN ITS ENTIRETY, INCLUDING ALL APPLICABLE SIGNATURES, AND RETURNED TO THE EMS SYSTEM COORDINATOR

WHILE IN THE PRE-HOSPITAL SETTING, THE ECRN WILL FUNCTION UNDER THE DIRECTION AND SUPERVISION OF THE SENIOR PARAMEDIC, AND, WHEN APPROPRIATE AND APPLICABLE, WILL BE GIVEN THE OPPORTUNITY TO PERFORM PATIENT CARE.

OBJECTIVE OF ECRN PRE-HOSPITAL RIDE TIME:

A. ESTABLISH A BASIC UNDERSTANDING OF PRE-HOSPITAL EMS CARE
B. PROVIDE FOR PROFESSIONAL GROWTH OF THE ECRN
C. ENSURE OPTIMUM LEARNING OPPORTUNITIES FOR THE ECRN
D. COMPARE AND CONTRAST THE PRE-HOSPITAL CARE SETTING VERSUS EMERGENCY DEPARTMENT CARE ENVIRONMENT
E. OBSERVE AND, WHERE APPROPRIATE, PARTICIPATE IN PRE-HOSPITAL PATIENT CARE
F. DESCRIBE OBSTACLES INVOLVED IN THE DELIVERY OF PRE-HOSPITAL PATIENT CARE
1. PERFORM PRE-HOSPITAL COMMUNICATIONS WITH THE RECEIVING HOSPITAL

THIS IS TO CERTIFY THAT _____, RN LICENSE NUMBER _____, HAS COMPLETED _____ HOURS OF PRE-HOSPITAL AMBULANCE RIDE TIME AS REQUIRED BY THE EMERGENCY COMMUNICATIONS REGISTERED NURSE (ECRN) CURRICULUM. WHEN SIGNED, THIS FORM SHALL SERVE AS OFFICIAL AND SUFFICIENT DOCUMENTATION OF COMPLETION OF THE NUMBER OF HOURS LISTED ABOVE, IN ACCORDANCE WITH CENTRAL DUPAGE HOSPITAL EMERGENCY MEDICAL SERVICES SYSTEM POLICIES AND PROCEDURES.

Date of Ride Time: ____/____/_____ Start Time: _____0800_____hrs End Time: _____1600_____hrs Number of Radio Calls to Receiving Hospital: _____5_____

Agency Where Ride Time Completed: Select EMS Agency Name

ECRN (OR CANDIDATE) PRINTED NAME: _____ SIGNATURE: _____

SENIOR PARAMEDIC OR PRECEPTOR PRINTED NAME: _____ SIGNATURE: _____

FORWARD THIS COMPLETED FORM TO THE CENTRAL DUPAGE HOSPITAL EMS SYSTEM OFFICE, ATTN: EMS SYSTEM COORDINATOR

DATE RECEIVED BY SYSTEM COORDINATOR: ____/____/_____ SYSTEM COORDINATOR SIGNATURE: _____

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Form #: CDHEMSS-008 ECRN Ride Time Verification Form
Approved: 02/2018 Revised: N/A