CENTRAL DUPAGE HOSPITAL
EMERGENCY MEDICAL SERVICES SYSTEM

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ECRN AMBULANCE RIDE TIME FORM

THIS FORM SHALL SERVE AS OFFICIAL DOCUMENTATION OF COMPLETION OF REQUIRED AMBULANCE RIDE TIME HOURS FOR CENTRAL DUPAGE HOSPITAL EMERGENCY MEDICAL SERVICES SYSTEM EMERGENCY COMMUNICATIONS REGISTERED NURSES (ECRN). THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED TO BE CONSIDERED VALID.

ONCE COMPLETED, THIS FORM IS TO BE SUBMITTED TO THE EMS SYSTEM COORDINATOR.

OBJECTIVES OF AMBULANCE RIDE TIME FOR ECRNS:

1. TO ESTABLISH A BASIC BUT ESSENTIAL UNDERSTANDING OF PRE-HOSPITAL EMERGENCY MEDICAL CARE.
2. TO PROVIDE FOR PROFESSIONAL GROWTH AND DEVELOPMENT OF THE ECRN.
3. TO ENSURE AN OPTIMUM LEARNING ENVIRONMENT FOR THE ECRN.
4. COMPARE AND CONTRAST, THROUGH DIRECT OBSERVATION AND PARTICIPATION, THE PRE-HOSPITAL CARE ENVIRONMENT VERSUS THE EMERGENCY DEPARTMENT SETTING.
5. OBSERVE AND PARTICIPATE, WHEN APPROPRIATE, IN PRE-HOSPITAL EMERGENCY MEDICAL CARE.
6. IDENTIFY AND DESCRIBE OBSTACLES AND CHALLENGES IN THE PROVISION OF PRE-HOSPITAL EMERGENCY MEDICAL CARE.
7. PERFORM RADIO COMMUNICATIONS, INCLUDING DELIVERY OF PATIENT CARE REPORT, TO RECEIVING HOSPITALS.

WHILE PARTICIPATING IN AMBULANCE RIDE TIME, THE ECRN OR ECRN CANDIDATE WILL FUNCTION UNDER THE SUPERVISION AND DIRECTION OF THE SENIOR PARAMEDIC, CREW CHIEF, PARAMEDIC-IN-CHARGE, OR OTHER APPROPRIATELY DESIGNATED PROVIDER. THE ECRN WILL BE GIVEN THE OPPORTUNITY TO PARTICIPATE IN DIRECT PATIENT CARE WHILE IN THIS CAPACITY, WITHIN THE ESTABLISHED SCOPE OF PRACTICE FOR PRE-HOSPITAL BASIC AND ADVANCED LIFE SUPPORT PROVIDERS.

ECRN OR ECRN CANDIDATE NAME: ____ DATE: _____/_____/______

RIDE TIME START: _____:_____HRS RIDE TIME END: _____:_____HRS TOTAL HOURS: ____________

EMS AGENCY WHERE RIDE TIME COMPLETED: ____ STATION OR AMBULANCE: __________________

NUMBER OF SUCCESSFUL RADIO CALLS TO RECEIVING HOSPITAL: ___________ LIST HOSPITALS CONTACTED FOR RADIO REPORT: ______________________________
____
____
____

ALL NAMES AND SIGNATURES ARE REQUIRED FOR RIDE TIME TO BE APPROVED.

PARAMEDIC PRINTED NAME: ______________________________ PARAMEDIC SIGNATURE: ______________________________

ECRN OR CANDIDATE PRINTED NAME: ______________________________ ECRN OR CANDIDATE SIGNATURE: ______________________________

****STOP** EMS PERSONNEL DO NOT WRITE BELOW THIS LINE. FOR ADMINISTRATIVE USE ONLY!**

EMS SYSTEM REVIEW: **APPROVED** **DENIED** **REASON DENIED:** ____

EMS SYSTEM COORDINATOR SIGNATURE: ______________________________________ DATE: _____/_____/______

EMS MEDICAL DIRECTOR SIGNATURE (NOT REQUIRED): ______________________________________ DATE: _____/_____/______

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FORM #: CDHEMSS-018 ECRN AMBULANCE RIDE TIME FORM
APPROVED: 08/2018 REVISED: N/A