Northwestern Medicine

McHenry Western Lake County EMS System

ECRN- EMS Ride Along

Validation Form

ECRN Candidate Name: _____ Date: _____

EMS Agency: _____ Station: _____

Time in: _____ Time out: _____

Number of ALS EMS Patients _____ (recommended 1)

Number of BLS EMS Patients_____

Summary of EMS ride along experience: _____

_____

_____

_____

Preceptor Comments: _____

_____

_____

EMS Paramedic Preceptor Name (please print): _____

EMS Paramedic Preceptor Signature: _____