REGION VII EMS
ECRN

CLINICAL FIELD EXPERIENCE / AMBULANCE RIDE-TIME
PRECEPTOR VERIFICATION REPORT FORM
(8 HOURS REQUIRED FOR NEW CANDIDATE LICENSURE)

ECRN – LAST NAME:_____________________________, FIRST NAME:_______________________

HOSPITAL AFFILIATION:______________________________________ SHIFT:________________

DATE OF RIDE TIME:__________________ AGENCY:____________________________________

STATION #:_________ UNIT # ASSIGNED TO:_________

TIME IN:_______AM/PM TIME OUT:_______AM/PM TOTAL HOURS LOGGED: ______

TOTAL # OF RUNS MADE:_______ # OF ALS:_______ # OF BLS:_______

NAME OF LEAD PARAMEDIC ON UNIT:_______________________________ SYSTEM #________

ADDITIONAL CREW MEMBERS:____

DESCRIPTION OF EXPERIENCE AND PERFORMANCE:_____________________________________

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SIGNATURE OF LEAD PRECEPTOR:___________________________________ SYSTEM #________

ECRN CANDIDATE SIGNATURE:____

Return this completed ride-time form to your EMS Coordinator for submission to the Resource Hospital for processing. Completion of this form is required for initial ECRN licensure.