EMS REGION 7
EMERGENCY COMMUNICATIONS REGISTERED NURSE
COURSE/SYSTEM ENTRY APPLICATION
(PLEASE PRINT LEGIBLY)

FOR COURSE CANDIDATES & SYSTEM ENTRY

Check One: ☐ **Registering for _____ (date) ECRN Course** **OR** ☐ **Licensed ECRN entering the System**

DATE: ___/____/____ **LAST NAME:** _____ **FIRST NAME**: _____

HOME ADDRESS: _____**CITY:** _____ **ST:** _____ **ZIP:** _____

CELL PHONE: (_____) _____ - _____ **R.N. LICENSE #:** _____

EMAIL: (print legibly)_____

SOCIAL SECURITY #:_____ **DATE OF BIRTH:** _____/_____/_____

EMS SYSTEM/RESOURCE HOSPITAL:_____

HOSPITAL WHERE YOU WORK: _____ **NORMAL SHIFT:** _____

CIRCLE ANY THAT APPLY

ECRN   EMT-B   EMT-I   EMT-P   PHRN   >IDPH License#_____

IF ALREADY LICENSD ECRN: DATE OF ORIGINAL ECRN COURSE: __ _/_ __/____ **REGION:** _____

CHECK AND COMPLETE ANY THAT APPLY

TNS ____ **Expiration Date:** ___/___/___ **IDPH License #**_____

TNCC ____ **Expiration Date:** ___/___/___

ACLS ____ **Expiration date:** ___/___/___ **PALS** ____ **Expiration date:**___/___/____

PHTLS ____ **Expiration date:** ___/___/___ **ITLS** ____ **Expiration date:** ___/___/____

ATTACH COPIES OF LICENSES AND CARDS (COPY ALL ON ONE PAGE).
SEND COMPLETED APPLICATIONS TO YOUR HOSPITAL'S EMS COORDINATOR,
WHO WILL THEN SEND APPLICATIONS TO THE SYSTEM RESOURCE HOSPITAL FOR PROCESSING.

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*Candidate's ER manager must sign for approval as well as System Resource Hospital EMS Coordinator.

_____   _____
ER Manager or EMS Coordinator Signature/Approval   **Silver Cross EMS Coordinator Signature/Approval**

10/16MM