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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 REGION VIII 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 YOUR ECRN COORDINATOR.

OBJECTIVE 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.

APPROVED PROCEDURES FOR ECRN RIDERS:	
PATIENT ASSESSMENT – PEDIATRIC AND ADULT	DEFIBRILLATION, CARDIOVERSION, & TRANSCUTANEOUS PACING
INTRAVENOUS ACCESS	OBTAIN VITAL SIGNS
INTRAOSSEOUS PLACEMENT	CPR
FLUID AND MEDICATION ADMINISTRATION	NEEDLE DECOMPRESSION
CARDIAC MONITORING	BLS AIRWAY MANEUVERS
12-LEAD EKG ACQUISITION	NOTE: INVASIVE AIRWAY PROCEDURES (INTUBATION & SURGICAL/NEEDLE AIRWAYS ARE NOT AUTHORIZED FOR THE ECRN TO PERFORM
OXYGEN ADMINISTRATION VIA NASAL CANNULA, NON-REBREATHER, AND BVM	

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, OR AS OTHERWISE LISTED ABOVE.

ECRN / CANDIDATE NAME: _____ DATE: _____ / _____ / _____

SPONSORING EMS SYSTEM: Central DuPage EMS System RIDE TIME START: _____:_____HRS RIDE TIME END: _____:_____HRS TOTAL HOURS: _____

EMS AGENCY WHERE RIDE TIME COMPLETED: Select EMS Agency STATION OR AMBULANCE CALLSIGN: _____

NUMBER OF SUCCESSFUL RADIO CALLS TO RECEIVING HOSPITAL: _____

LIST HOSPITALS CONTACTED FOR RADIO REPORT:
Select Hospital Contacted
Select Hospital Contacted
Select Hospital Contacted
Select Hospital Contacted

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

PARAMEDIC PRINTED NAME: _____ PARAMEDIC SIGNATURE: _____

ECRN/CANDIDATE PRINTED NAME: _____ ECRN/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: _____ / _____ / _____

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