

REGION 7 EMS
ECRN ALS RIDE TIME LOG FORM
(PLEASE PRINT)

**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: _____

SIGNATURE OF LEAD PRECEPTOR: _____ SYSTEM # _____

ECRN CANDIDATE SIGNATURE: _____

Return completed competency form to mzanelli@silvercross.org as this is required for ECRN licensure.