REGION 7 EMS
ECRN COURSE APPLICATION / SYSTEM ENTRY APPLICATION
FOR COURSE CANDIDATES & SYSTEM ENTRY

Check One: ☐Registering for _________________________ (date) ECRN Course.
☐Licensed ECRN entering the System.

DATE: ____/____/____ LAST NAME: _________________________ FIRST NAME: _____________________

HOME ADDRESS: _______________________________CITY: __________________ ST: ____ ZIP: _________

CELL PHONE: (_____) __________ - _______________ R.N. LICENSE #: ____________________________

DATE OF BIRTH:_______/________/____________

E-MAIL (PRINT LEGIBLY): ____

HOSPITAL WHERE YOU WORK Circle One: Silver Cross or Saint Joes

EMS SYSTEM: Silver Cross EMS System

CIRCLE ANY THAT APPLY

ECRN EMT EMT-I PARAMEDIC PHRN > & include IDPH License#_____________

IF ALREADY LICENSED AS AN ECRN: GIVE DATE OF ORIGINAL ECRN COURSE: __ _/_ __/____ and what Region:________

CHECK AND COMPLETE ANY THAT APPLY

TNS ____ Expiration Date: ___/___/___ IDPH License #________________

TNCC ____ Expiration Date: ___/___/___ PHTLS ____ Expiration date: ___/___/___

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

ATTACH CLEAR/LEGIBLE COPIES OF LICENSES AND CARDS. SEND COMPLETED APPLICATION TO YOUR HOSPITAL'S EMS COORDINATOR, WHO WILL SUBMIT TO THE SYSTEM RESOURCE HOSPITAL FOR PROCESSING.

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

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ER Manager or designee Signature/Approval Silver Cross EMS Coordinator or designee Signature/Approval