MORRIS HOSPITAL EMS SYSTEM
EMERGENCY MEDICAL DISPATCHER
EMD PROGRAM

CLINICAL FIELD EXPERIENCE / AMBULANCE RIDE-TIME PRECEPTOR – VERIFICATION REPORT FORM

LAST NAME: _____ FIRST NAME: _____

DISPATCH AFFILIATION: _____ SHIFT NORMALLY WORKED: _____

DATE OF RIDE TIME: _____ / _____ / _____ AGENCY: _____

STATION #: _____ UNIT # ASSIGNED TO: _____

TIME IN: _____ : _____ TIME OUT: _____ : _____ TOTAL HRS: _____

OF RUNS MADE: _____ # OF ALS RUNS: _____ # OF BLS RUNS: _____

NAME OF LEAD PARAMEDIC (PRINT) _____

ADDT'L CREW NAMES: _____ / _____

DESCRIPTION OF EXPERIENCE AND PERFORMANCE:

_____

_____

_____

_____

SIGNATURE OF LEAD PARAMEDIC: _____

EMD CANDIDATE OR RELICENSURE SIGNATURE: _____